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NEW PERSPECTIVES IN HEALTH CARE FOR OLDER AMERICANS

(RECOMMENDATIONS AND POLICY DIRECTIONS OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE)

REPORT

TOGETHER WITH ADDITIONAL AND SUPPLEMENTAL VIEWS

BY THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

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FOREWORD

PRIORITIES OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

The Subcommittee on Health and Long-Term Care came into existence on February 20, 1975. Over the past 10 months, the subcommittee has heard 182 witnesses during 11 days of formal and informal hearings [1] in Providence, R.I., Miami, Fla., and Washington, D.C. The subcommittee has been in contact with over 1,000 organizations and individuals with expertise in the health needs of the elderly, including State health departments, State commissioners on aging, the chairmen of all State House and Senate health committees, health consumer organizations, health providers, and other national and local organizations.

As a result of these efforts, the subcommittee has found two priority areas in great need of attention:

(1) The need to correct the proliferation and fragmentation of health programs for the elderly on a Federal level, both in the Department of Health, Education, and Welfare, and in the Congress; and on the State and local levels as well;

(2) The need to correct an emphasis on institutionalization in Federal statutes and in the Department of Health, Education, and Welfare, and to establish a comprehensive system of home health and supportive services designed to permit the elderly patient, often inappropriately institutionalized, to remain in the dignity of his own home and community.

The report and the recommendations which follow are by no means uncontroversial. The subcommittee made a decision to say what has to be said and to recommend what it believes to be right.

The subcommittee considered every recommendation. Because the subcommittee fully understands that all will not be enacted or implemented immediately, some recommendations have been proposed as alternative to others. However, as current statutes and administrative practices exist, the subcommittee believes that each recommendation would be effective now and would assist the elderly citizens of this country.

We issue this report and these recommendations on the basis of exhaustive hearings. Unfortunately, we have found that documentation coming from the Department of Health, Education, and Welfare has often been confused and lacking. Therefore, we are hopeful of obtaining further substantiation and direction from the Department, from other experts in the field, and from the public as a whole.

The subcommittee considered the question of the cost of the proposed recommendations. It concluded that the proposals to end proliferation

[1] See Appendix III for list of witnesses and hearings.

and fragmentation could *reduce* cost. The proposals providing home health care to persons inappropriately institutionalized would *reduce* costs—testimony before the subcommittee indicated by as much as $700 million nationwide (nursing homes are a $9 billion industry). Provision of care to additional persons who would apply for home care but who would enter nursing homes only as a last resort *would* cost, but much of this cost would be saved by the fact that, in the future, many persons will be able to avoid institutionalization or decrease the length of stay. While some experts say there will even be an overall saving, the evidence does tend to indicate there will be an increase in cost because of an increase in the number of persons who will seek the more humane benefits to be provided. During the coming year the subcommittee will continue to conduct research into the cost and savings implications of the recommendations.

The subcommittee believes that, even if there is to be an increase in costs, the elderly of the nation deserve far better health care than they are now receiving. An affluent society is obligated to undertake the responsibility to minimize the illness and suffering of its aged population.

This report represents an initial step in the efforts of this subcommittee to assess the health needs of the elderly. The priorities determined to date are based on the first 10 months' work, and the evaluation process will be continued in these and other areas of concern.

The subcommittee intends to conduct further research into the issues raised and to strengthen and revise the recommendations as changing national health situations and new documentation may direct. The subcommittee will continue to work toward implementation of both the current and new recommendations as justified by the facts.

The report and the recommendations are divided into five categories:

(a) Introduction: Developing a Continuum of Care for the Elderly:

(1) Proliferation and Fragmentation: A National Phenomenon.

(2) Home Health Services: A Right to Choose.

(3) Innovative Alternatives to Institutionalization.

(4) Nursing Home Auditing and Standards.

(5) Important Areas for Further Study in Long-Term Care.

The introduction sets forth a framework for the subcommittee's provisions and future efforts, and calls for a new national policy in long-term care for the elderly which takes into account a medical-social model rather than one of purely acute medical services. The chapter on "Proliferation and Fragmentation" cites some of the numerous programs, statutes, and agencies which make extraordinarily complex the elderly patient's process of obtaining benefits.

In discussing alternatives to institutionalization, "Home Health Services" is first because the subcommittee believes that home health care is the primary alternative to institutionalization. The discussion of "Innovative Alternatives" which follows is based on the premise that the individual's living at home rather than in an institution is socially and in many cases economically preferable. The chapter on "Nursing Home Auditing and Standards" reflects the subcommittee's concern that, although emphasis should be given to developing home health care as the primary long-term care strategy, nursing homes are still a vital part of the Nation's elderly health delivery system. The concluding chapter, "Important Areas for Further Study," discusses the subcommittee's specific plans for the coming year.

NEW PERSPECTIVES IN HEALTH CARE FOR OLDER AMERICANS

(Recommendations and Policy Directions of the Subcommittee on Health and Long-Term Care)

INTRODUCTION

DEVELOPING A CONTINUUM OF CARE FOR THE ELDERLY

The Subcommittee on Health and Long-Term Care of the House Select Committee on Aging has begun a comprehensive series of investigations on the organization and delivery of a continuum of care to the elderly.

The subcommittee is seeking to redress the lack of public and Congressional attention given to planning and implementing key programs that will benefit the elderly and the current unilateral focus on curative programs in existing health legislation. Dr. Stanley Brody of the University of Pennsylvania has said:

> While the aged have need for acute medical care, their major requirement is in the continuum of services for the chronically disabled that will enable them to function optimally. Any health system which continues to be limited to a disease orientation will not meet the increasing needs of the aging community. Medical services must take their place as a part—and only part—of the continuum of health care.[1]

The medical model meets the acute, episodic needs of the patient. The objectives for acute care are to help the patient through the acute crisis as speedily as possible. In the process of treating acute illness, all the other needs of the patient become secondary. Success is measured in improvement or recovery terms. The health-social services model places greater emphasis on secondary needs. Instead of a disease orientation, health-social services place emphasis upon the patient's potential to function in the social, professional, and family spheres of his family. Success is measured in terms of actual level of functioning compared to potential level rather than a set textbook utilization review procedure.

A prime objective of this subcommittee in view of the findings of its past investigations is to further explore present and proposed policies of the Federal Government toward providing health-social services and to recommend a series of actions which must be taken by the Congress and the Executive Branch to insure that policies which are initiated under the justification of meeting the health needs of older Americans do in fact meet these needs. This concentration on health-social services does not imply a denigration of acute medical delivery to older Americans; rather it will determine the need for

[1] Stanley Brody: "Comprehensive Health Care For The Aged: An Analysis," The Gerontologist, Winter, 1973.

the elevation of health-social services care professions to equality, visibility and recognition comparable to that of the medical model.

Elderly persons are not a homogeneous group, but many of them require community or institutional health and social services to stay alive, active and productive. Of particular need in the delivery of services to the elderly is an approach which coordinates such services as homemaking, transportation, counseling, group activities, aide services, and ambulatory monitoring of chronic illness with institutional and residential forms of medical and social care.

Essential to the understanding of recommendations that the subcommittee will be setting forth later and those proposed in this report is the recognition that there is an urgent need to reconstruct our health care financing system to match services to patient placement in a specific institution or organization. Congress must know which services are needed now, for which persons, and at what cost in order to enact legislation. Of major importance in developing rational legislation is finding a means to coordinate existing community resources with newly-developed Federal and Federal-State programs.

Developing new programs in isolation has proven to be an inefficient way to allocate resources. The Congress must learn to spend dollars on projects that will alleviate some of the consequences of growing old and will permit older Americans to actively contribute as part of their community.

At the root of present practice are two limiting factors which cause an institutional bias in the health care system and retard the provision of needed care to a sizable patient population.

First, both government and carriers of health insurance accept as given a tightly defined medical model as the premise for defining benefits and payments. It is this carefully defined clinical-treatment system that sets in motion the machinery to justify admission, treatment modalities, utilization, lengths of stay, and monitoring the quality and quantity of care. While this medical model meets the acute, episodic institutional needs of the patient it overlooks the patient's potential to function in the social and family spheres of his life at home. The objective of this care is only to help the patient through the acute crisis as quickly as possible. Success is measured in recovery terms. The services, facilities, and resources needed to attain a recovery are usually finite.

The medical model has severe limitations which hamper its application in designing benefits for chronic illness, geriatrics and long-term care services. The complexity of multiple-diagnoses and chronic illness conditions, combined with social, emotional, economic and other fragilities common to many chronically ill persons, limit the application to a tightly defined clinical-treatment system.

Second, it is the norm under present practice to describe the scope of and eligibility for health care services in terms of levels. The levels of care needed by the users and the level of service provided by classes of providers not only have complicated and limited the provision of patient care, but have also created an administratively cumbersome mechanism for monitoring the quality and quantity of services.

This develops an artificial classification of both patient and providers. Superimposed upon patient need is a rigidly defined benefit structure complete with limitations upon lengths of stay and eligi-

bility for placement. Providers are grouped according to an array of rather complex, lengthy and unwieldy regulations. This erroneously implies that most users have the same needs which require the same sets of services and that all providers in a class are alike and have the same capacity to furnish the same sets of services.

Working in tandem, the medical model as the premise for entry into and exit from the health care reimbursement program, and the artificially defined levels of care as the basis for payment and placement, contribute to the following problems:

(1) Delayed entry into the health system through limitations that prevent early detection and treatment;

(2) Lack of incentives for optimum use of health resources and cost-efficient use of home health services;

(3) Increased dependency upon institutionalization for individuals whose needs are for maintenance and rehabilitation rather than "cure";

(4) Continuum of minimal standards for providers which in turn discourages the provision of individualized care.

(5) Over-emphasis of quantitative factors such as size of physical facility rather than quantitative results that can be measured through periodic use of a patient functional assessment evaluation instrument; and

(6) Neglect of the needs of a sizable patient population whose requirement for care does not conform to the artificial structure of the reimbursement systems.

Commitment of additional funds to programs based on these existing approaches may only increase confusion, lack of coordination, and poor service for the elderly.

The most direct route to developing a sound legislative approach is to go beyond examination of separate categorical programs in isolation from their effects on each other on the elderly. What is most critically needed as we face the prospects of a national health system and examine the efficiency and effectiveness of our existing health and welfare programs, is a systematic investigation of each major influence on the quantity and quality of care services delivered to the elderly.

The subcommittee in its future investigations will gather testimony and data that will make interdependent relationships explicit between such factors as financing of health care, provider training, and institutional resources and will assess their respective contributions to producing sufficient and good care. From these studies, realistic projections of cost, cost-effectiveness, and benefits of the current and proposed recommendations set forth in the report (especially Recommendation No. 1) will be derived, and the relationship between medical-social programs of special interest to the elderly and those of general interest to all citizens can be assessed.

Consistent with its above stated objectives, the subcommittee will orient its investigations towards community-based programs which develop increased local initiative, unfettered by conflicting Federal-State jurisdiction and regulations.

The subcommittee will seek ways to allow older Americans themselves to participate more fully in their community and receive more

care per dollar spent. Concomitant with this focus will be analysis of long-term care options that have potential for delivering a full spectrum of care services for the elderly and contain provisions which permit public accountability.

The subcommittee will also examine and seek remedies to an unfortunate and degrading social phenomenon that has been brought on by current legislative policy; namely, the requirement that the elderly be driven into a state of legal and actual poverty in order to gain the benefits from public health and long-term care programs.

The subcommittee will propose a relationship between long-term care programs and national health insurance and recommend a design for an optimum balance of social and medical services for the elderly.

The project in effect has begun with this report, which summarizes current long-term care options for the elderly, and recommends what might be done under present legislative and fiscal conditions to provide a continuum of care to the elderly.

The subcommittee will continue to work on this report by analyzing, in greater detail, service programs which have the potential to be prototypes for larger efforts in the field.

CHAPTER I

PROLIFERATION AND FRAGMENTATION: A NATIONAL PHENOMENON

During the hearings of the subcommittee, "proliferation" and "fragmentation" have been two of the most commonly used terms to describe the plethora of Federal laws and programs for elderly health and the multitude of agencies and organizations that administer them.

Consider the following: [1]

In the Department of Health, Education, and Welfare, the Assistant Secretary for Health coordinates the National Institutes for Health, the Health Services Administration, the Health Resources Administration, the Center for Disease Control, the Alcohol, Drug Abuse, and Mental Health Administration, and the Food and Drug Administration. The Area Offices on Aging (under the Commissioner on Aging) administer home health aids and homemaker services under the Older Americans Act. The Social and Rehabilitation Service coordinates the Medical Services Administration, which administers medicaid, and SRS also coordinates the Rehabilitation Services Administration and other programs.

Social Security Administration's Bureau of Health Insurance administrates medicare. Special assistants to the Secretary are appointed to fill desired ad hoc elderly health needs. The Office of Nursing Home Affairs theoretically coordinates Departmental long-term care programs but has no real line authority (see next chapter).

This partial listing barely touches the surface of the complexity of HEW's elderly health organization.

One witness told the subcommittee that "it would take a Philadelphia lawyer to lead a person through the layers of red-tape to find the right service at the right time."

Nowhere is fragmentation and proliferation more evident than in the delivery of home health services.

Programs which provide medical or supportive services for the elderly in their homes include medicare (title XVIII of the Social Security Act), medicaid (title XIX), the new Social Services Program (title XX), the Public Health Service Act Amendments (new home health grants), State and community grant programs for the elderly (title III of the Older Americans Act), nutrition programs for the elderly (title VII), the Senior Companion Program and Retired Senior Volunteer Program (RSVP) both under title II of the Domestic Volunteer Service Act, and Older American Community Service Employment Program, Senior Opportunities and Services under the Community Services Act, and others.

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[1] See Rufus E. Miles, Jr., "The Department of Health, Education, and Welfare," Praeger, New York, 1974, pp. 73–77, 133; and Claire Townsent, "Old Age: The Last Segregation," Grossman, New York, 1971, pp. 218–219.

Dr. Arthur S. Flemming, U.S. Commissioner on Aging, testified before the subcommittee on November 19:

Although a wide range of in-home and community based services are available to maintain older persons in their homes, most of these services are fragmented, financed under different Federal programs with differing eligibility requirements, income levels, and sometimes conflicting regulations.

For medicaid and title XX social services, the State and local welfare offices or the social services department are responsible.

For SSI, the disabled individual must contact the Social Security District Office, and have his case periodically reviewed.

For medicare, identification cards are provided by the Social Security Administration.

Older Americans Act services under titles III and VII are provided by a variety of public and private non-profit organizations generally at the community level.

Individuals needing a range of services frequently complain about the physical dexterity and transportation costs required to travel from agency to agency—the agencies being dispersed over wide areas.

There is proliferation in Congress too. Health jurisdiction is distributed among at least three committees in the House of Representatives—Interstate and Foreign Commerce, Ways and Means, and Education and Labor—with resulting fragmentation and a lack of rationality in health planning. Home health and nursing home benefits under medicare for example, are considered by the Ways and Means Committee, home health and nursing home benefits under medicaid are considered by the Interstate and Foreign Commerce Committee, and homemaker services under the Older Americans Act are under the jurisdiction of the Committee on Education and Labor.

From the standpoint of oversight, one of the subcommittee's prime goals for the coming year is the establishment of a simplified or streamlined administrative vehicle through which all programs and funds for the maintenance of the mental and physical health of older Americans would be funneled in a rational and cost-effective manner to the target population they were designed to reach. Such a vehicle would cut administrative costs and allow the money saved to be applied to expanded services and direct patient health care.

CHAPTER II

HOME HEALTH SERVICES: A RIGHT TO CHOOSE

> "The poorest man in his cottage may bid defiance to all the forces of the crown. It may be frail. The roof may leak, the rains may enter, the storm may enter—but the King of England cannot enter—all his force dare not cross the threshold of the ruined tenement."—*William Pitt* (speech before the House of Lords, England, 1766).

It is a tragedy of our times that we as a Nation should find ourselves in the position of thinking of home health care for the elderly as an alternative to institutionalization. Somehow, it shocks the conscience and goes against the grain to deal with the subject in that context. *It only stands to reason that in the natural order of things it should be just the reverse. Institutionalization should be an alternative to home health care.*

While there will always be highly disabled patients who require full-time institutionalization in nursing homes, persons capable of remaining in their own homes *should have the right to choose.*

Institutional Bias

It is the intent of this report to examine the national emphasis on institutionalization, a concept that has evolved both from compromises made in statutes (the acute-care basis of medicare and medicaid in 1965) and the tangled bureaucratic web of HEW, where it has taken shape in the Office of Nursing Home Affairs and elsewhere.

At times HEW officials wax eloquently on "viable alternatives to premature institutionalization." They are not consistent in this. For example, the Department testified:

> It has only been in the past two decades that home health services have been recognized as a promising approach which may help resolve the complex problems hampering the efficient and effective delivery of health care in the United States.[1]

Yet what is the Department of HEW doing about the bias in favor of institutionalization?

Office of Nursing Home Affairs Chairs HEW Interagency Home Health Task Force

HEW testified:

> In January of this year the Secretary reaffirmed the Public Health Service as the lead agency for coordinating and monitoring the implementation of the Department's *short-term* (emphasis added) *home health care improvement efforts.* This responsibility has been assigned to the Office of Nursing Home Affairs.

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[1] Peter Franklin testifying before the Subcommittee on Health and Long-Term Care, August 7, 1975, transcript p. 614.

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Imagine—to the Office of Nursing Home Affairs. *The Office of Nursing Home Affairs is the lead agency for home health.*

HEW continued:

> The Office of Nursing Home Affairs chairs an Inter-Agency Task Force on home health services. This Task Force includes representatives from the Social Security Administration, the Social and Rehabilitation Service, the Administration on Aging and the Office of the Secretary.[2]

On its face there is something wrong with the structural setup of the task force on home health.

Mr. Franklin further stated:

> The other experiment I would like to cite, Mr. Chairman, is an experiment being carried out here in Florida, specifically in Tampa, to develop and implement a new health care delivery system for the patient needing long-term care. The purpose of the experiment is two-fold: first, to develop *through the collaboration of nursing homes*, medical care facilities and services, health and social service agencies and programs, a realistic community plan which will enable nursing homes to utilize community resources in order to meet the needs of in-patients or to plan for a patient's return to community living * * *[3]

Dr. Faye G. Abdellah, Assistant Surgeon General and Director, HEW Office of Nursing Home Affairs, shed further light on the subject under questioning by Chairman Pepper:

> Our Office of Nursing Home Affairs is limited to the policy coordination of these services. That is, our responsibility would be working with all of the agencies concerned with home health services and to give some overall oversight direction to the implementation.[4]

HEW's Long Term Care Facility Improvement Study [5] points out further that "to avoid duplication", *ONHA "coordinates* efforts throughout the Department" in "research and development and data collection * * * through contracts and grants" concerning "*assessment of alternatives to institutional care*".

The subcommittee questions the propriety of placing home health services under the jurisdiction of the Office of Nursing Home Affairs. The nursing home industry and the home health industry are, at least theoretically, competing for the same market.

In addition, while the Office of Nursing Home Affairs has been given the task of coordinating the long-term care service programs of the Department, the subcommittee is concerned as to whether an instrument of the Public Health Service can in fact coordinate the functions of the two primary reimbursement programs (medicare and medicaid). Medicare and medicaid are under the functional control of two distinct organizational units within the Department, the Social Security Administration's Bureau of Health Insurance and the Social and Rehabilitation Service's Medical Services Administration, which are not subject to the primary control of the Assistant Secretary for Health who oversees the Public Health Service. ONHA is neither a line function nor does it have authority over the Bureau of Health Insurance (medicare) nor over the Medical Services Administration (medicaid).

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[2] Peter Franklin testifying before the subcommittee on August 7, 1975, transcript p. 614.
[3] Peter Franklin testifying before the subcommittee, August 7, 1975, Miami, Fla.
[4] Testimony, subcommittee hearings, Miami, Fla., August 5–8, 1975.
[5] Public Health Service, Office of Nursing Home Affairs, Department of HEW, "Long-Term Care Facility Improvement Study," Introductory Report 1975, p. 2. Also see "Federal Register," Nov. 26, 1975, p. 55145.

The subcommittee commends the Secretary for establishing an ad hoc interagency task force to better coordinate policy, particularly in the writing of recommendations. However, even aside from the seeming titular conflict of interest, the structural situation forces the subcommittee to conclude that ONHA cannot be an effective mechanism either to stem abuses in institutional long-term care or to develop quality home health care.

The power to force compliance with ONHA decisions has never existed except to the extent that ONHA can persuade BHI or MSA to follow its recommendations. ONHA, because of its structural situation, is extremely limited in its authority to enforce any decision which it makes regardless of whether they are nursing home decisions or home health decisions.

"Presumed Coverage" Home Health Regulations Restrict Home Health Benefits

Medicare regulations proposed during 1975 by the Department of Health, Education, and Welfare would discriminate against home health, in the view of the subcommittee. A brief summary of the issues follows:

"Presumed coverage" for home health under medicare, published in the July 9 Federal Register,[6] would create a fixed formula for post-hospital and post-extended care facility home health services, specifying the allowable number and length of visits under certain patient conditions.

BACKGROUND

The 1972 Social Security Amendments (P. L. 92–603) included a provision (Section 228) for advance approval of post-hospital extended care and home health services under medicare. This provision authorized the Secretary to establish, by diagnosis, periods during which a post-hospital patient would be presumed to be eligible for home health services. The Secretary was directed to take into account "the severity of condition", the "degree of incapacity," and the minimum period of home confinement generally needed for such conditions.

The Committee reports[7] cited "retroactive denial" as the main reason for this section of the legislation. "Retroactive denial" is the process whereby the intermediary—the third party, usually an insurance company making the payment—refuses to reimburse care *after* the patient receives it, on the ground that the care was not covered under the law (which was ambiguous on the subject).

However, the committee report also stated that the legislation would provide a dual advantage over the present system of coverage determination by:

(1) Encouraging prompt transfer through assurance that the admission or start of care will be reimbursed, and

(2) Identifying in advance the point at which further assessment should be made, on an individual care basis, of continuing

[6] *Federal Register*, July 9, 1975, Proposed Rules for Presumed Level of Care (Section 228 of P.L. 92–63).

[7] House Report 92–231, May 26, 1971; see also Senate Report 92–1230, Sept. 26, 1972, and Conference Report 92–1605, Oct. 14, 1972.

need for extended or home health care. Where request for coverage beyond the initial presumed period, accompanied by appropriate supporting evidence, is submitted for timely advance consideration, it is expected that a decision to terminate extended care or home health coverage would ordinarily be effected on a prospective basis. For those conditions for which specific presumed periods cannot be established, current procedures for determining coverage would continue to apply.

The effective date was January 1, 1973.

Another provision, Section 213, effective October 31, 1972, is referred to as the "Waiver of Liability" provision. This section permitted both the individual and provider to qualify for waiver, i.e.: "nor be held responsible for repayment of incorrect amounts" where it can be determined that they are without fault.

This was effective October 31, 1972.

FINDINGS

The subcommittee believes that home health agencies today do not need "presumed level" to provide relief on retroactive denials because the regulations implementing "waiver" of liability and adjustments by fiscal intermediaries have virtually eliminated the retroactive denials and have improved provider intermediary communications on "Covered Care."

A comparison of covered post-hospital home health services with the "Presumed Level" indicates that the regulations, intentionally or unintentionally, will reduce coverage of post-hospital home health services. This is clearly in conflict with the legislative intent of this provision.

The subcommittee received letters and comments on the regulations from home health providers, consumer organizations, and others. Specific problems cited which the regulations would cause include:

Fiscal intermediaries will restrict covered visits to those listed; preclude daily visits; fail to include provision for home health aide, occupational therapy and social services visits; fail to identify and state the relationship between coverage and the minimum presumed levels; one hour time limit; additional paperwork caused by additional certifications; do not consider that teaching is based on intelligence, patient receptivity, supervision and environment; require additional recertification procedures; inadequately list procedures; do not provide for changing conditions (emergency, etc.); do not use a statistical basis for visits; mandate extra paperwork because 90% would require extension requests; do not provide for more visits at first, initially to be tapered off; will be used by intermediaries to determine eligibility for part "B" patients; provide no allowance for more acute patients; do not provide consideration for an initial evaluation visit; fail to take into account changing of conditions; and do not consider individual needs or physician orders.

The Institutional Syndrome

An "institutional syndrome" has been discussed by many experts, and is believed to develop so rapidly after institutionalization in skilled nursing facilities that—

* * * certain dependencies develop that are not normal. People become dependent on an institution for services that perhaps if they had remained, say, in their own home that they could have continued to perform for themselves.[8]

Yet the subcommittee finds that current law discriminates in favor of institutional care even when it may be inappropriate and more expensive. For example, the current medicare provision of 100 post-hospital nursing home days (and more when recertified) compares with an allowance of 100 far less expensive home health "visits"; there is a 3-day hospitalization requirement before receiving medicare part A home health benefits, thereby often preventing needed home health care which can assist in stopping the necessity of a hospital stay; medicare provisions cover prescription drugs and diagnostic screening in nursing homes and hospitals but not as part of home health; and, of course, room, board, and maintenance and custodial services are covered in institutions but not at home. In addition, testimony before the subcommittee has demonstrated conclusively that the health of the elderly is based not only on physical but social and psychological factors as well, and that registered nurses, certified social workers, guidance counselors, home health aides, and other health professionals, who often play the key role in patient care, should have a major part in decision making. The medicare and medicaid restriction of "home health" to care prescribed and supervised by doctors greatly limits the development and use of effective home health services.

Over the last decade, the nursing homes have gotten a lion's share of Federal dollars and home health services only an extremely small portion. 1974 figures indicate that under medicare part A (hospital insurance), home health bills for the elderly represent about 10 percent of all billings, or $78 million of the $7.3 billion expenditures for part A. Under part B (supplementary medical insurance) home health bills are about 1 percent of all bills, or $35 million of the $4 billion of supplementary medical insurance expenditures.[9]

Under medicaid there is no breakout for home health services provided *exclusively* to older persons, but the expenditure for 1974 home health services for all age brackets was $31 million—about .3 percent of the $10.1 billion medicaid expenditures. With a national elderly population of 21 to 22 million out of over 10 million people over 21 in the United States, it is clear that less than 1 percent of medicaid home health funds are for the elderly. Moreover, medicare benefits replace many medicaid services for many needy and indigent persons over 65. Finally, of the $31 million, $19 million was spent in two states—Massachusetts and New York State—$16 million for New York State alone.[10]

The following charts are Government figures on home health reimbursements together with other health cost reimbursements:

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[8] Peter Franklin, Special Assistant to Secretary of HEW, testifying before the subcommittee, July 12, 1975, Providence, R.I.
[9] Hearing transcript, "Comprehensive Home Health Services," November 19, 1975.
[10] Ibid.

TABLE M-20.—OASDHI medical insurance: Number of reimbursed bills for physicians' and related services and amount reimbursed, by type of service, type of beneficiary, and period recorded, as of March 29, 1975 [1]

[In thousands]

Period recorded [2]	All services [3]		Physicians		Outpatient hospital		Independent laboratory		Home health		All other [4]	
	Number of bills	Amount reimbursed [5]	Number of bills	Amount reimbursed [5]	Number of bills	Amount reimbursed [5]	Number of bills	Amount reimbursed [5]	Number of bills	Amount reimbursed [5]	Number of bills	Amount reimbursed [5]
	Total [6]											
Jan. 1, 1969–Dec. 31, 1969	39,941	$1,783,402	33,508	$1,614,299	3,556	$68,125	615	$8,677	573	$30,971	1,636	$58,987
Jan. 1, 1970–Dec. 31, 1970	39,695	1,750,536	32,850	1,572,749	4,031	84,551	665	9,406	430	22,676	1,715	61,058
Jan. 1, 1971–Dec. 31, 1971	44,947	1,956,471	37,109	1,748,272	4,528	101,778	957	12,309	297	15,825	2,054	75,053
Jan. 1, 1972–Dec. 31, 1972	51,754	2,227,043	42,164	1,971,579	5,668	135,629	1,278	16,508	278	15,228	2,366	82,951
Jan. 1, 1973–Dec. 31, 1973	43,508	1,918,896	34,272	1,655,467	5,403	146,979	1,167	15,375	268	17,171	2,157	82,300
Jan. 1, 1974–Dec. 31, 1974	67,995	3,189,502	54,190	2,675,850	8,026	303,998	1,858	25,946	477	38,273	3,247	138,435
July 1, 1973–Dec. 31, 1973	20,507	914,510	15,763	775,110	3,003	79,627	532	7,074	120	8,589	1,064	43,229
Jan. 1, 1974–June 30, 1974	35,862	1,674,818	29,468	1,450,221	3,498	125,022	955	13,252	205	15,499	1,632	67,145
July 1, 1974–Dec. 31, 1974	32,133	1,514,683	24,722	1,225,629	4,528	178,976	902	12,694	272	22,774	1,615	71,209
Jan. 1, 1975–Mar. 28, 1975	18,033	866,040	14,599	695,443	2,450	99,594	563	8,127	130	10,414	846	50,387
	Persons aged 65 and over [7]											
July 1, 1973–Dec. 31, 1973	20,339	905,085	15,654	768,302	2,954	77,573	531	7,051	118	8,444	1,058	42,847
Jan. 1, 1974–June 30, 1974	34,217	1,564,585	28,252	1,378,874	3,199	92,664	928	12,814	194	14,451	1,545	62,317
July 1, 1974–Dec. 31, 1974	29,928	1,368,043	23,252	1,145,798	4,000	122,939	860	11,994	254	21,044	1,477	63,209
Jan. 1, 1975–Mar. 28, 1975	17,293	768,241	13,671	645,463	2,165	68,635	534	7,648	111	9,583	761	35,018
	Disability beneficiaries [8]											
July 1, 1973–Dec. 31, 1973	168	9,425	109	6,808	49	2,054	2	23	2	145	7	352
Jan. 1, 1974–June 30, 1974	1,645	110,233	1,217	71,347	298	32,358	27	433	11	1,048	87	4,828
July 1, 1974–Dec. 31, 1974	2,205	146,640	1,470	79,832	528	56,037	43	699	18	1,730	139	8,061
Jan. 1, 1975–Mar. 28, 1975	1,340	97,800	928	49,979	285	30,959	29	479	9	831	85	15,369

[1] Includes only those bills for which reimbursements were made by carriers or intermediaries and that were recorded in the Social Security Administration central records before Mar. 29, 1975.

[2] Determined by summarization date of administrative records. If days from more than 1 month are included in period summarized, data are prorated by month according to the number of calendar days represented in each month.

[3] Included in total, but not shown separately, are data for which type of service is unknown.

[4] Includes bills for (a) ancillary and other miscellaneous SMI services provided by hospitals, skilled-nursing facilities, and home health agencies; (b) chronic renal dialysis services furnished by limited-care facilities; (c) hospital-based physicians' services with charges calculated on a per diem rate; and (d) supplier (other than independent laboratory) services.

[5] Amount reimbursed to or in behalf of the beneficiary—generally 80 percent of the allowed charges, once the beneficiary has satisfied the $60 deductible in the current year (before Jan. 1, 1973, the deductible was $50). Some radiology and pathology services are reimbursed at a 100-percent rate, regardless of beneficiary's deductible status. Beginning calendar year 1973, home health services provided under the supplementary medical insurance program are reimbursed at 100 percent of the reasonable cost less any applicable deductible.

[6] Through June 1973, includes data for services rendered to beneficiaries aged 65 and over. Beginning July 1973, includes data on bills paid for services rendered to beneficiaries aged 65 and over, and the new group of beneficiaries who became entitled to supplementary medical insurance on or after July 1, 1973 (effective date for this provision of the 1972 amendments). The new group includes persons entitled to Medicare because they meet the disability provisions of the Social Security Act and those entitled solely because of chronic renal disease.

[7] Includes a relatively small number of persons aged 65 and over entitled to supplementary medical insurance benefits solely because of chronic renal disease.

[8] Includes a relatively small number of persons under age 65 entitled to supplementary medical insurance benefits solely because of chronic renal disease.

[Reprinted from "Social Security Bulletin," July 1975]

TABLE M-18.—OASDHI hospital insurance: Number of bills approved for payment and amounts reimbursed, by type of benefit, type of beneficiary, and period approved, as of December 28, 1974 [1]

[In thousands]

Period approved [2]	Total [3]		Inpatient hospital		Home health		Skilled-nursing facility	
	Number	Amount reimbursed [4]	Number	Amount reimbursed [4]	Number	Amount reimbursed [4]	Number	Amount reimbursed [4]
	Total [5]							
January 1970–December 1970	7,462	$4,821,025	6,278	$4,548,553	567	$46,484	617	$225,987
January 1971–December 1971	7,350	5,337,972	6,407	5,121,239	492	41,844	451	174,889
January 1972–December 1972	7,591	5,863,999	6,678	5,663,406	523	48,169	390	152,425
January 1973–December 1973	8,067	6,536,189	7,037	6,303,194	593	57,419	436	175,576
July 1973–December 1973	4,062	3,306,577	3,537	3,184,319	301	29,884	225	92,375
January 1974–June 1974	4,546	3,863,515	3,963	3,757,874	348	36,414	235	99,228
July 1974–September 1974	2,099	1,881,329	1,854	1,824,295	100	18,530	84	35,503
	Persons aged 65 and over [6]							
July 1973–December 1973	3,852	3,138,568	3,335	3,018,447	295	29,240	221	90,881
January 1974–June 1974	4,202	3,585,276	3,644	3,454,718	330	34,375	229	96,183
July 1974–September 1974	1,931	1,726,312	1,693	1,671,649	151	17,392	82	37,270
	Disability beneficiaries [7]							
July 1973–December 1973	211	168,009	202	165,872	5	643	3	1,494
January 1974–June 1974	344	308,239	320	303,156	17	2,039	6	3,044
July 1974–September 1974	168	155,017	156	152,646	9	1,138	2	1,233

[1] Includes only those bills recorded in the Social Security Administration central records before Dec. 28, 1974. A bill does not necessarily represent a total stay in a covered facility or a complete series of visits covered under an established home health plan. Usually, more than one bill is submitted for each stay in a long-term hospital or in a skilled-nursing facility and for visits under a home health plan. Because of lags in bill processing by intermediaries and the Social Security Administration, data for recent months are incomplete; comparison of most recent months with similar months in earlier years are, therefore, not valid.

[2] Period in which the intermediaries approved bills for payment.

[3] Included in total, but not shown separately, are bills for outpatient diagnostic services approved for payment under the hospital insurance program.

[4] Actual benefit payments as represented in trust fund transactions differ from amounts reimbursed as shown above, which represent payments for covered services, based on an interim rate (either per diem or a percent of total charges) and adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation. Payments exclude deductible and coinsurance amounts and noncovered services as specified by law.

[5] Through June 1973, includes only data on bills paid for services rendered to beneficiaries aged 65 and over. Beginning July 1973, includes data on bills paid for services rendered to beneficiaries aged 65 and over and the new group of beneficiaries who became entitled to hospital insurance benefits on or after July 1, 1973 (effective date for this provision of the 1972 amendments). The new group includes persons entitled to Medicare because they meet the disability provisions of the Social Security Act and persons entitled solely because of chronic renal disease.

[6] Includes a relatively small number of persons aged 65 and over entitled to hospital insurance benefits solely because of chronic renal disease.

[7] Includes a relatively small number of persons under age 65 entitled to hospital insurance benefits solely because of chronic renal disease.

The chronology of the development of the home health industry follows a very similar pattern to the development of nursing homes—a rapidly burgeoning industry. While the subcommittee wholeheartedly supports and encourages the development of home health care, the Congress must mandate care of a quality nature to avoid the same mistakes of the nursing home industry.

Within 9 months, between September 1965, when the funds became available, and July 1, 1966, when the benefits became effective, "home health services improved as never before".[11] The number of programs increased, as did the range of services offered. By October 21, 1966, 1,256 agencies had been certified under P.L. 89–97, The Social Security Amendments of 1965, and others were operating as local outposts of State agencies or were potentially certifiable in their own right.

Are they growing financially?

	Millions
Fiscal year 1972, medicare reimbursement	$59
Fiscal year 1973, medicare reimbursement	75
Fiscal year 1974, medicare reimbursement	110

Despite such growth, home health receives a miniscule portion of national health expenditures. Preliminary figures for 1975 of the Social Security Administration cited by the Committee for National Health Insurance show the following estimated breakdown of $118.5 billion spent in Fiscal Year '75 for medical costs (Private—$68,552; Public—$49,948):

1975 medical expenses in United States[1]

	Billions
Health services and supplies	$111.250
Physician services	22.100
Dentist	7.500
Other professional services	2.180
Drugs and drug sundries	10.600
Eyeglasses and appliances	2.300
Nursing home care	*9.000*
Expenses for prepayment and administration	4.593
Government public health activities	3.457
Other health services	3.000
Research and medical facilities construction	7.250

[1] Social Security Administration, USDHEW, Staff Paper No. 1, 1975, provided to subcommittee by Committee for National Health Insurance.

Conspicuous by its absence is a figure for home health care estimated to be well under $400 million.[12]

Yet, P.L. 89–97 and P.L. 90–248, the Social Security Amendments of 1965 and 1967, require State medicaid plans to provide home health services, and P.L. 89–97 also states that home health services must be reimbursed under medicare.

Cost Effectiveness of Home Health Care

The issue of the comparative costs of home health care and other alternatives to institutionalization arose throughout the subcommittee's investigations.

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[11] Peter Franklin testifying before the Subcommittee on November 19, 1975.

[12] The National Association of Home Health Agencies, December 1974, estimated national home health medical expenditures at $315 million.

A report by the Department of Health, Education, and Welfare argues that—

> * * * to proceed with the development of a national policy, to recommend the reallocation of large sums of public funds, and to encourage or stipulate a major increase in resources and activity, is a risky venture in the absence of more definitive verification (of the economics of home health).[13]

The subcommittee agrees that cost comparisons have often been of limited empirical value. However, most of the negative cost comparisons have attempted to equate the use of home health services to the acute medical model rather than to adjust for the effectiveness of preventive and maintenance aspects of home health. In a macro-analysis of home health costs, three observations become apparent:

(*a*) The role of preventive medicine (which are currently largely negated by current requirement for prior hospitalization to be eligible for medicare home health) indicates favorable long term costing;

(*b*) Expansion of home health care will probably bring an increase in public health costs but through an expanded service population, not through a per-patient health cost; and

(*c*) Narrow economic costing models often neglect to evaluate the favorable social and health costs associated with retention in the community.

As Dr. Philip Weiler argues in The Gerontologist:

> At the present time there cannot be rational [cost-effective] analysis of the geriatric health-care system as long as it remains imbedded in a system which is essentially only acute-care oriented. In order to develop the proper objectives a long-term care orientation is needed . . .
>
> Although it seems obvious, we have been late in realizing the acute-care model cannot fit the problems of long-term care. Long-term care requires that the social needs of the patient be given primary importance and the medical needs secondary importance. Medical needs must be structured into a matrix of other needs and not vice versa. Success cannot be measured in "cure" terms, but in the level of functioning of the patient in relation to a broad spectrum of parameters (e.g., physical, medical, social parameters, activities of daily living, mental health, and family life). Effect should be measured in terms of the patient's functioning, with his actual level of functioning compared to the potential level for each parameter. The long-term care model is not locked in on diagnosis. It is more important to know the effects on the way the patient functions.
>
> Especially since the advent of Medicare and the subsequent demand on health-care services for the elderly, it has become evident that the planning for such services based on the acute-care model is totally cost-ineffective. The objectives of such services have either been vague (i.e., nursing care, custodial care), or inappropriate (i.e., cure), or entirely lacking. Using the acute-care model, health services have been provided for the elderly as if these were their dominant need (at times this may be the case because the elderly also get acutely ill, but 80% have chronic problems, which is the primary problem).
>
> The health services that have been delivered are usually in settings which call for a suspension of all other needs of the elderly. The results, therefore, have been less than encouraging.[14]

The Minneapolis Age & Opportunity Center (MAO), a very innovative multipurpose outpatient center for the elderly in Minneapolis, offered convincing testimony on the cost-effectiveness and the human-

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[13] Applied Management Sciences "Interim Report," Contract #HEW-OS-74-294, Jan. 3, 1975, Vol. 1, cited in Marie Callendar and Judy La Vor, "Home Health Care Development: Problems, and Potential" in Disability Long Term Care Study, DHEW, April 1975, p. 53.

[14] Dr. Philip Weiler, "Cost Effective Analysis: A Quandry for Geriatric Health Care Systems," The Gerontologist, October 1974, pp. 414 and 415.

effectiveness of home health and supportive care. MAO, a non-profit organization working with a "consortium" of Federal, State, local and private "partners," provides an alternative health and health-social system for people who do not require 24-hour care.

Daphne Krause, Executive Director of MAO, testified before the subcommittee on July 8, 1975. Mrs. Krause stated that, during any period, MAO is providing "medi-supportive" services to 8,000 people, voluntary action programs to 29,000 people and clinical services to 3,800 people. "We have over 5,000 people waiting to get our services," Mrs. Krause explained, "and we do not know if those are the only people who need them." [15]

Senator Hubert Humphrey of Minnesota, a guest of the subcommittee during the hearings on MAO, pointed out the effectiveness of MAO and the mechanism of a consortium of partners: "It really is * * * one of the curses of our modern society, whether we have international problems or domestic problems, we say . . . write a check, rather than try to figure out how we can put human resources to work * * *" [16]

Among the supportive services MAO offers are:

1. Home delivered meals
2. Employment service
3. Home care services
4. Handyman services
5. Transportation services
6. Legal services
7. Counseling services
8. Information and referral services
9. Special health services
10. Facilitation of health services
11. Decentralized miniclinic services

In support of her thesis of the cost-effectiveness of home health care, Mrs. Krause presented a number of case studies to the subcommittee.[17]

The subcommittee believes that the evidence, presented in charts to the committee, does demonstrate the cost-effectiveness of MAO's approach. While the subcommittee would caution that the savings indicated may not be universally applicable and that it cannot be absolutely ascertained that the individuals assisted by MAO would otherwise have been institutionalized on a full-time basis, the evidence indicates a great potential for cost savings under certain conditions.

The charts [17] follow:

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[15] Testimony before subcommittee, "Innovative Alternatives to Institutionalization," July 8, 1975, p. 6.
[16] Ibid, p. 82.
[17] Hearing on "Innovative Alternatives to Institutionalization," July 8, 1975, p. 32, et seq.

COST EFFECTIVENESS OF M.A.O. HOMECARE PLAN VERSUS INSTITUTIONALIZATION #427E

COST IF CLIENT WAS INSTITUTIONALIZED OVER 3 MO. PERIOD

	COST
BASIC COST OF NURSING HOME AT $450/mo - 3 MOS.	$1,350.00
MINUS CLIENT'S INCOME OF $118/mo. FOR 3 MOS. CLIENT WOULD BE ALLOWED $25/mo FOR PERSONAL NEEDS	- 354.00
COST TO TITLE XIX	$ 996.00

COST OF M.A.O. SERVICES OVER A 3 MO. PERIOD

SERVICES	NUMBER OF SERVICES	
HANDYMAN	1	$ 27.75
HOMECARE	3	11.10
COUNSELING	23	230.00
TRANSPORTATION	3 (TO SEE HUSBAND IN HOSPITAL)	10.50
	TOTAL	$ 279.35

(N.B. THE LIFT WAS ON LOAN WITHOUT CHARGE. IF MR P HAD LIVED LONGER, THEN SOME CHARGE WOULD HAVE HAD TO BE ARRANGED.)

COST EFFECTIVENESS

	COST
COST TO TITLE XIX OF INSTITUTIONALIZATION FOR 3 MONTHS	$ 996.00
MINUS COST OF M.A.O SERVICES FOR 3 MOS.	- 279.35
TOTAL SAVINGS TO TITLE XIX	$ 716.65

THEREFORE, "TITLE XIX" COULD PAY FOR ALL M.A.O. SERVICES, AND STILL SAVE THE TAXPAYER $716.65 OVER A 3 MONTH PERIOD AS MAO DID

COST EFFECTIVENESS OF M.A.O. HOMECARE PLAN VERSUS HOSPITALIZATION #440E

BASIC COST IF CLIENT WAS HOSPITALIZED FOR 14 DAYS

AVERAGE BASIC COST OF HOSPITALIZATION FOR 14 DAYS	$2,184.00
LESS DEDUCTIBLE ABSORED BY ABBOTT-NORTHWESTERN/M.A.O. SENIOR CITIZEN CLINIC	- 94.00
	$2,090.00
LESS CO-INSURANCE 20% OF REMAINER WHICH ABBOTT-NORTHWESTERN/M.A.O. CLINIC ABSORB	- 418.00
Since Mrs D was not hospitalized, Medicare was saved.....	$1,672.00

COST OF M.A.O. SERVICES FOR ONE MONTH

SERVICES	NUMBER OF SERVICES	COST
HOME DELIVERED MEALS (diabetic)	2 MEALS/DAY, 7 DAYS/WEEK, 3 WEEKS (CLIENT PAID $1.85/DAY)	$ 10.50
TRANSPORTATION	2	6.80
COUNSELLING	4	27.62
DIETARY CONSULT	1	8.50
	TOTAL	$ 53.42

COST EFFECTIVENESS

COST TO MEDICARE FOR 14 DAY HOSPITALIZATION	$1,672.00
MINUS COST OF M.A.O. SERVICES FOR 1 MONTH	- 53.42
TOTAL SAVINGS TO MEDICARE	$1,618.58

THEREFORE, MEDICARE COULD PAY FOR ALL M.A.O. SERVICES AND STILL SAVE THE TAXPAYER $1,618.58 AS M.A.O. DID.

COST EFFECTIVENESS OF M.A.O. HOME CARE PLAN VERSUS INSTITUTIONALIZATION

COST IF CLIENT HAD BEEN INSTITUTIONALIZED 59 MONTHS

	COSTS
AVERAGE BASIC COST OF NURSING HOME CARE AT $540/MONTH FOR 59 MOS	$31,860.00
LESS CLIENT'S INCOME OF $121/MO HE WOULD HAVE BEEN ALLOWED $25/MO	$ 7,139.00
COST TO TITLE XIX	$24,721.00

COST OF M.A.O. SERVICES OVER 59 MONTHS

SERVICE	NUMBER OF SERVICES	COST
HOME DELIVERED MEALS	2 MEALS/DAY, 7 DAYS A WEEK, 348 DAYS	$ 817.80
HOME CARE	1 (SERVICE REGULALY BY FAMILY)	3.99
CHORE	1 " " - "	3.99
TRANSPORTATION	101	343.40
COUNSELING	97	284.75
VOLUNTEER	2	1.00
	TOTAL	$ 1,454.93

COST EFFECTIVENESS

COST TO TITLE XIX OF INSTITUTIONALIZATION FOR 59 MONTHS	$24,721.00
MINUS COSTS OF M.A.O. SERVICES - 59 MOS.	- 1,454.93
TOTAL SAVINGS TO TITLE XIX	$23,266.07

THEREFORE, "TITLE XIX" COULD PAY FOR ALL M.A.O. SERVICES, AND STILL SAVE THE TAXPAYER $23,266.07 OVER A 59 MONTH PERIOD AS M.A.O. DID.

COST EFFECTIVENESS OF M.A.O. HOMECARE PLAN VERSUS INSTITUTIONALIZATION '42 P.S.

COST IF CLIENTS WERE INSTITUTIONALIZED OVER 22 MONTHS

BASIC COST OF NURSING HOME AT $450/mo :	COST
FOR MR O - 22 MONTHS	$9,900.00
FOR MRS. O - 20 MONTHS	9,000.00
TOTAL	$18,900.00
MINUS CLIENTS' INCOME OF $186/mo CLIENTS WOULD HAVE BEEN ABLE TO KEEP $28/mo FOR PERSONAL NEEDS	-4,092.00
COST TO TITLE XIX	$14,808.00

COST OF M.A.O. SERVICES OVER 22 MONTHS

SERVICE	NUMBER OF SERVICES	COST
HOME DELIVERED MEALS	2 meals/day, 7 days/week for both Mr & Mrs O	$ 3,295.00
COUNSELING	20	310.00
VOLUNTEER SERVICES	172	86.00
	TOTAL	$ 3,691.00

COST EFFECTIVENESS

COST TO TITLE XIX OF INSTITUTIONALIZATION FOR 20 & 22 MOS. FOR MR & MRS O.	COST $14,808.00
MINUS COSTS OF M.A.O. SERVICES	-3,691.00
TOTAL SAVINGS TO TITLE XIX	$11,117.00

THEREFORE, "TITLE XIX" COULD PAY FOR ALL M.A.O SERVICES & STILL SAVE THE TAXPAYER $11,117.00 OVER 22 MOS. AS M.A.O. DID.

The following additional studies presented to the subcommittee further demonstrate the cost-effectiveness of home health care.[18]

REPORTED SAVINGS ON HOSPITAL COSTS THROUGH HOME CARE*

SELECTED STUDIES

This paper summarizes data on savings in hospital costs resulting from early discharge to home health care as reported in selected studies in New York State and elsewhere. Various other reports now available could have been included, but the number has been restricted in the interests of brevity.

Studies selected represent programs at three levels—statewide, metropolitan area, a single community hospital.

Figures are given below which summarize savings in hospital days and hospital costs reported in these studies. Later tables give source references and additional breakdown data.

REPORTED HOME CARE SAVINGS

Study report	Hospital days saved per patient	Net savings per patient [1]
Visiting nursing service, Denver, 1971	15.6	$1,170
Blue Cross, Philadelphia, 1963–71	12.9	330
St. Luke's Hospital, Denver, 1970	14.0	850
Blue Cross, Connecticut, 1970–72	21.6	2,175
Patients in traction, Rochester, 1973	49.8	4,590
Blue Cross, Michigan, 1961–70	14.7	562

[1] Figures are net savings—costs of home care deducted from estimated savings in hospital costs.

A number of comments are in order with reference to the above figures:

First, reported hospital days saved in the Philadelphia, Connecticut, Denver VNA, and Michigan studies are based on estimates made by attending physicians. Figures in 4 of the 5 studies fall within a relatively narrow range of 12.9 to 15.6 days saved. Such a result involving hundreds of physicians and thousands of patients in so many parts of the country strongly supports the validity of the data even though an element of subjective judgment is involved. (See Table V for explanatory comments on the higher Connecticut figures).

Second, data in the St. Luke's and McGill University reports are based on carefully designed control studies. Savings reported are based on objective data comparing selected groups receiving hospital care only, and groups receiving hospital plus home health services.

Third, the substantial reductions in hospital stays reported in the hemophiliac and traction case studies add an important dimension to the cost effectiveness potential of home care. The number of such patients in the population, of course, is relatively small. However, in view of the very high dollar savings, there is strong indication that earlier discharge to home care for these and other special disability groups—post-surgical, pediatric, coronary, pulmonary, to name a few—could add up to an impressive cost reduction.

Fourth, taken together these studies present a strong weight of evidence that home care can make significant savings in hospital days. Admittedly, there are limitations in the studies. But it would seem imprudent to ignore the evidence of these reports while awaiting some more comprehensive research project for which there is presently no visible sponsor or source of funding.

Meanwhile, the explosion in health costs continues. Careful clinical studies consistently report unnecessary hospital and nursing home use, a portion of which could be reduced by home care. Over 42 percent of Medicaid expenditures in the state in 1970 were for hospital care, and more than 24 percent for nursing home care. Only a fraction goes for low-cost care in the home.

The cost situation and the data in this report strongly suggest the timeliness for action on home care.

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[18] The information was collated and supplied to the subcommittee by Edward G. Lindsey, Director of Health Services, State Communities Aid Association, New York.

*Prepared by Edward G. Lindsey, Director of Health Services, State Communities Aid Association, New York, New York.

ADDITIONAL DATA ON STUDIES

Tables I through VII which follow present additional data on the home care studies cited on page 1. In some instances for convenience, figures have rounded to the nearest dollar.

Denver Early Discharge Program

Table I below summarizes data reported by the Denver Visiting Nurse Service on the 1971 Early Discharge Program. The study involves 620 patients referred to home care by 10 voluntary hospitals.

TABLE I.—*Denver early discharge program—Hospital days saved,*[1] *1971*

Hospital days saved per patient[2]	15.6
Hospital savings per patient[2]	$1,472
Home care cost per patient[2]	$302
Net savings	$1,172

[1] "Report of Early Discharge Program," Visiting Nurse Association, Denver, Colorado, 1972.
[2] Based on average hospital per diem of $95.

An additional 768 patients were referred to home care, but not designated as "early discharge." Data on these patients is not included in Table II.

Philadelphia Blue Cross Study

Table III below summarizes data on hospital days saved as reported in a home care study by Blue Cross of Greater Philadelphia. The study covered a ten (10) year period—1961–70, and provides figures on 3,940 patients discharged to home care by four (4) hospitals during that time.

TABLE III.—*Hospital days saved—Philadelphia Blue Cross,*[1] *1961–70*

Hospital days saved per patient	12.9
Hospital savings per patient	$634
Home care cost per patient	$304
Net savings per patient	[2] $330

[1] "Coordinated Home Care: An Effective Alternative," Blue Cross of Greater Philadelphia, February 1972.
[2] A net savings of $473 per patient was later reported for the year ending June 30, 1970.

Estimated hospital days saved on 3,940 cases totaled 50,800 days valued at $2,495,267. Net savings after deducting costs of home health services and related administrative costs were estimated at $1,298,381.

St. Luke's Hospital Study, Denver

Table IV below summarizes data on hospital days saved as reported in a controlled study by J. W. White at St. Luke's Hospital, Denver, Colorado in 1970. The study involved one sample of 100 patients referred by the Hospital Nurse Coordinator's Office to home care, and a second sample of 100 patients selected on admission until "the same number of cases for each diagnostic category was reached" as in the home care sample.

TABLE IV.—STUDY OF HOSPITAL DAYS SAVED THROUGH REFERRAL TO HOME CARE[1]—ST. LUKE'S HOSPITAL, 1969

	Hospital days	Hospital cost[2]	Home care cost	Total cost
Hospital group	2,554	$196,504	----------	$196,504
Home care group	1,155	88,935	$22,534	111,469
Net savings				85,035

[1] "A Comparison of Referred and Nonreferred Cases to Home Nursing Care," unpublished masters thesis, J. W. White, M.A. Hospital Administration, 1970.
[2] Average per diem (St. Luke's, 1969), $77.

Hospital days saved averaged 14.0 days per patient. Hospital costs saved averaged $1,076 per patient. Home health services averaged 36.4 days per patient. Net savings were $850 per patient, a cost reduction of over 43 percent.

A General Accounting Office analysis of 20 studies by experts comparing the cost of home health care with the cost of institutional services developed the following conclusion:

Of the 20 studies, 19 presented data which supported the proposition that home health care can be less expensive under some circumstances than alternative institutional care.[19]

The individual's right to choose should be preserved.

Need for Home Care

The subcommittee has examined various surveys which attempt to assess the extent of need for home health services. The subcommittee has concluded that there are from 2.0 to 3 million noninstitutionalized aged persons who are bedfast, homebound, or have difficulty in getting outdoors without help.

The National Council of Senior Citizens estimates that 1 out of 6 older Americans who are not in institutions are in need of direct health and social services if they are to be able to remain in their own homes and communities.[20]

Preliminary estimates by the National Association of Home Health Agencies indicate that home health agencies are serving less than 15 percent of the projected national need.[21]

Using statistics from a one month survey in eastern Massachusetts, a Brandeis University study stated. "The total volume of delivered home health aides and home help reached only 2.5 percent of the persons estimated to be in serious need . . ." [22]

Particularly poignant is the fact that 54 percent of the Nation's counties have no medicare-certified home health agencies.[23]

144,000 to 400,000 Nursing Home Patients Should Be Freed:

There are over 1 million elderly persons in long-term care institutions today. Many of them have been placed there because there were no alternatives available to them.

A January 1975 study contracted by HEW cited figures indicating that between 144,000 and 260,000 people, or between 14 to 25 percent of the approximately 1,000,000 elderly persons in skilled and intermediate nursing homes, may be "unnecessarily maintained in an institutional environment." [24]

A 1972 GAO report reveals that:

There is a consensus among health care authorities that about 25 percent of the patient population are treated in facilities which are excessive to their needs.

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[19] General Accounting Office, letter to Representative Edward I. Koch, September 17, 1975.

[20] Rudolph Danstedt, testifying before the subcommittee, November 19, 1975.

[21] Donald Trautman, National Association of Home Health Agencies, testifying before the subcommittee, June 16, 1975.

[22] Ibid.

[23] HEW statistics, April 1975, supplied by Library of Congress.

[24] Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled, Interim Report No. 3: Assessment of the Feasibility of Conducting a Prospective Study of Clients Served by Alternatives to Institutional Care: Volume 1, January 3, 1975" (Prepared by Applied Management Sciences, Office of the Assistant Secretary for Planning and Evaluation, Dept. of HEW, pursuant to Contract No. HEW-08-74-294), placed into the *Congressional Record* by Representative Edward I. Koch, April 14, 1975, p. H2728.

The report continues:

> The health care system is oriented primarily toward treatment of the acute phase of illness and does not offer a complete spectrum of health care by providing available alternatives to acute care, financing for the alternatives, and educating physicians and patients in accepting alternatives.
>
> Home care can be viewed as meritorious by itself in that it provides the most appropriate care to the patient which best fits his needs. Patients on home care also pay a good deal less than the rate they would have to pay in a general hospital, and there is a growing sentiment among medical economists that a well-conceived home care program could make unnecessary the construction of a substantial number of new general hospital beds.[25]

Other reports indicate that at least in some areas of the country, these figures may even be conservative. The Levinson Gerontological Policy Institute of Brandeis University, in testimony before the subcommittee, spoke of—

> * * * the high proportion of persons forced into nursing homes because no alternative home care provision is available, even though they do not require institutional care for medical reasons.

Dr. Robert Morris, testifying on behalf of the Institute, said that "the percentage of such unnecessary institutionalization . . . depending on the area of the country studied", ranges from 10 percent to as high as 40 percent.[26]

While discussing home health legislation during the subcommittee's November 19, 1975, hearing on "Comprehensive Home Health Care," HEW said, "We find very little, if any, evidence of that (patients using up allowable medicare home health visits) occurring." HEW also stated, "We are opposed to such (expansion of home health) legislation because there is inadequate justification." HEW testified that "additional experiments" are needed to "provide a sound basis for any proposed changes." Yet, on September 17, 1975, the Social Security Administration, within HEW, had provided information to GAO demonstrating that 1,965, or 1.4 percent, of medicare part B home health recipients *used up the allowable benefits* in 1974 and about 2 percent, or 3,000 people, exhausted their part A home health benefits. Such patients then have no covered alternatives but expensive hospital or nursing home care.

The subcommittee supports the Department's attempts to gather data. We ask that HEW promptly report on the results of its ongoing experiments concerning the effectiveness of homemaker services as a means to delay or prevent institutionalization under Section 222 of Public Law 92–603. That project period ended January 27, 1976.

However, the subcommittee sees the call for additional experiments as a delaying tactic. The subcommittee has conducted months of hearings and gathered voluminous data demonstrating the cost-effectiveness and care advantages of home health. We already have the experiences and the data to back up the need for legislation. We are sorry the Department does not.

The subcommittee believes that the time for relying on new experiments had ended, and the time for meaningful legislative reform to make home health care a reality is now.

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[25] Study of Health Facilities Construction Cost," General Accounting Office, November 20, 1972, p. 10.

[26] Dr. Robert Morris, Director, Levinson Gerontological Policy Institute, Brandeis University, testimony before the subcommittee, June 16, 1975.

The recommendations of the 1971 White House Conference on Aging, which this committee is mandated by law to oversee, were as follows regarding home health:

Summary of Home Health Recommendations, 1971 White House Conference on Aging

The five major recommendations set forth basic goals for a comprehensive, effective program of *homemaker and home health services.* Briefly, they are stated as follows: (1) such services *must be a required benefit in any elderly health and welfare program in which the Federal Government participates financially. In addition, such services must be broadly defined*, with flexible eligibility conditions, widely available, and well publicized; (2) such services must have adequate public funds and be available free, or on a sliding scale of fees, to the recipient or through third party payments; (3) all agencies providing such services must meet nationally established standards; (4) other related in-home services must be available to coordinate with homemaker and home health aide services; and (5) homemaker and home health aide services must be available as supportive, protective, and preventive services on a flexible basis as needed whether on a continuing supportive basis or for only a temporary period of time.

The subcommittee believes that *it is past time to implement these recommendations of the White House Conference on Aging.*

CHAPTER III

INNOVATIVE ALTERNATIVES TO INSTITUTIONALIZATION

A review of both the testimony before the subcommittee and the literature on the health care needs of aged Americans demonstrates that many of the Nation's elderly are confined in institutional settings simply because alternative living arrangements for more appropriate support and care are not available. At the same time, it is recognized that the elderly utilize health care services more intensively than other age group categories. The care which many elderly individuals require to allow them to return to their homes and to maintain their independence includes expanded home health and homemaker services, as discussed earlier. However, the subcommittee has found that for many elderly individuals, *outpatient health services* available on a periodic or regular basis—in conjunction with needed home health services—would be a more appropriate alternative.

Outpatient Clinics Emphasizing Geriatrics

The subcommittee believes that outpatient health services provided in *outpatient clinics emphasizing care of the elderly* but not exclusively for elderly persons should be provided. Services should include a combination of primary medical (preventive, interventionary, and referral); dental, ophthalmic; otologic; podiatric; rehabilitation; mental health; and health education services.

Testimony has been presented to the subcommittee demonstrating that while outpatient clinics for the elderly are not unique, they are by no means common. Clinics specializing in elderly care exist in such cities as San Diego and Minneapolis.[1] Still other health center services for the elderly are provided by home health agencies in apartment buildings and housing units for the elderly or in area schools or churches. It has been found that such services have served to reduce total health care costs by reducing tenant visits to physicians and clinics; by reducing transportation problems and costs; by providing referral information for community resources; and by preventing hospitalization with early recognition of health problems that can be treated at home.

Such care is less costly than full-time hospital care, nursing home care, and often even home health care, because the center delivers a whole range of services by a variety of providers. In addition, such centers assist in the important principle of keeping the patient in the community.

A Department of HEW study, "Health Service Use, National Trends and Variations, 1953–1971," (No. 73–3004, October 1972)

[1] See "Innovative Alternatives to Institutionalization," hearing before the Subcommittee on Health and Long-Term Care, July 8, 1975.

found that, in 1970, for 16 percent of those persons 65 and over, a clinic served as a regular source of care. Another *11 percent of individuals 65 and over were found to have no regular source of care available.*

Multipurpose Senior Centers

Another alternative which the subcommittee believes should be encouraged, *multipurpose senior centers*, has been found to serve a very valuable community service for health services, nutrition programs, and referral services. They are also a means of bringing elderly persons together in a social setting to relieve the pain of loneliness suffered by so many.

The subcommittee has found that senior centers which provide *comprehensive services*—health, nutrition, recreation, and social programs—can provide a meaningful life for many elderly persons who would otherwise be institutionalized.

A 1974 survey conducted by the National Institute of Senior Centers (NISC) found 4,870 senior centers and clubs with regular activities for older persons. Of the 4,706 for which service data were available, 1,967 provided less than the three basic services (set forth by NISC) of education, recreation, and information, and referral or counseling; 255 provided these three basic services; 1,471 others provided these services plus community volunteer activities for older persons; and another 1,003 provided all these services plus health services. Of the total 4,870, only 1,474 provided health services and 1,476 provided nutrition services.[2]

According to another recent survey, 18 percent of persons aged 65 and over (approximately 3.7 million people) had attended a senior center in the past year or so. However, almost as many (17 percent) said they would like to attend a senior center but didn't. Of these, over one million said they "didn't attend because there were no known facilities where they were." This number, which could be interpreted as needing a senior center, would increase if persons aged 55 to 64 were added.[3]

Additional Alternatives

The subcommittee heard testimony concerning a variety of additional alternatives to institutional care and believes the following should be encouraged.

Community care organizations, providing a package of home health and related services including Meals on Wheels, homemaker, home maintenance, snow shoveling if necessary, lawn mowing and other gardening; and medical and health related services, including physical therapy, visiting nurses, guidance and counseling, social workers if needed, and physicians.

Elderly day health care centers, where health professionals perform identical or similar services to those by participants in skilled nursing facilities and intermediate care facilities, especially for persons in those facilities as a transitional step toward full recovery and a return to their homes in the community.

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[2] Data provided by Library of Congress.

[3] "The Myth and Reality of Aging in America" by Louis Harris and Associates for the National Council on Aging, pp. 134–138.

The subcommittee further believes that *nursing homes and ICF's should be encouraged to provide alternative day modes* (with adequate standards against abuse) so that the elderly individual can see the entire continuum of care available to him in the same location *so as not to become unnecessarily accustomed to remaining in the institution*, and so that a possible transfer back home will be accomplished by continuing health care with which the patient feels comfortable.

Geriatric *mobile health units*, providing regular medical services for persons over 60, which would travel to various locations on a regular basis.

Expansion of mobile and stationary *emergency health units* specializing in the emergency health needs of the elderly.

Annual "*Health Fairs*" in communities, to provide free medical checkups, appropriate referrals, and printed information relating to health education. One such fair in Coral Gables, Fla., found an individual with brain damage who had to be rushed to a hospital emergency room.

CHAPTER IV

NURSING HOME AUDITING AND STANDARDS: PRELIMINARY FINDINGS

The subcommittee recognizes the need for adjustments in long-term care regulations, standards, and review procedures which would enhance their appropriateness, efficiency, effectiveness, and compatibility. However, the subcommittee has gathered data and testimony which points to glaring deficiencies in enforcement of existing regulations or implementation of sound procedures for auditing.

Dearth of Audits

At a hearing of the subcommittee in Providence, R.I., on July 12, 1975, "Auditing of Nursing Homes and Alternatives to Institutionalization," HEW revealed that since the inception of Medicaid there was a dearth of audits of nursing homes not only in Rhode Island but across the Nation. During the period from 1966 to 1975 20 States did not conduct a single audit of a medicaid eligible long-term care facility (see exhibits I and II). In addition, many of the audits listed in the table took place only after a nursing home scandal was revealed, as in the case of New York State or Rhode Island where 20 of the 27 total audits performed since 1967 had been done in the previous 6 months before the hearing on July 12, 1975. As of December 1975 there were 11,785 facilities eligible to receive medicaid long-term care funds.[1] These statistics point to the urgent need to develop a rational scheme of financial auditing; one that would permit the States, the Federal Government, and the public to monitor the use of Federal and State funds, as appropriate, under current statutes and regulations, or if necessary under new statutes or regulations.

Exhibit I

Number of medicaid facilities audited by State organizations *

Alabama	55	Hawaii	NA
Alaska	0	Idaho	3
Arizona	(1)	Illinois	398
Arkansas	0	Indiana	0
California	0	Iowa	0
Colorado	1	Kansas	36
Connecticut	0	Kentucky	94
Delaware	24	Louisiana	206
District of Columbia	0	Maine	75
Florida	0	Maryland	543
Georgia	0	Massachusetts	600

[1] Does not participate in the medicaid program.
NA—Information not available.

* Since Enactment of Medicaid. Chart taken from testimony of HEW during subcommittee hearing, July 12, 1975 (Providence).

[1] Source: Office of Nursing Home Affairs, Jan. 14, 1975.

EXHIBIT I—Continued

Michigan	1370	Oregon	57
Minnesota	51	Pennsylvania	319
Mississippi	0	Rhode Island	27
Missouri	350	South Carolina	38
Montana	1	South Dakota	0
Nebraska	0	Tennessee	60
Nevada	16	Texas	375
New Hampshire	25	Utah	0
New Jersey	316	Vermont	0
New Mexico	36	Virginia	170
New York	222	Washington	0
North Carolina	87	West Virginia	0
North Dakota	0	Wisconsin	487
Ohio	4	Wyoming	0
Oklahoma	0	Puerto Rico	0

EXHIBIT II

HEW Audit Agency audit reports issued by State since 1967

Alabama	4	Montana	1
Alaska	2	Nebraska	4
Arizona	(1)	Nevada	1
Arkansas	2	New Hampshire	5
California	11	New Jersey	2
Colorado	7	New Mexico	2
Connecticut	5	New York	20
Delaware	2	North Carolina	1
District of Columbia	2	North Dakota	3
Florida	4	Ohio	3
Georgia	3	Oklahoma	2
Hawaii	3	Oregon	5
Idaho	3	Pennsylvania	7
Illinois	9	Rhode Island	4
Indiana	4	South Carolina	3
Iowa	2	South Dakota	0
Kansas	3	Tennessee	3
Kentucky	3	Texas	2
Louisiana	1	Utah	4
Maine	4	Vermont	2
Maryland	5	Virginia	4
Massachusetts	8	Washington	4
Michigan	4	West Virginia	2
Minnesota	5	Wisconsin	4
Mississippi	3	Wyoming	2
Missouri	4	Puerto Rico	1

[1] Does not participate in the medicaid program.

Some preliminary data and testimony has been gathered by the subcommittee on the cost and benefits of unannounced on-site auditing of Federally funded skilled nursing, and intermediate care facilities. The testimony from Federal and State officials on the estimated cost of such auditing has varied widely. The Department of Health, Education, and Welfare estimated the average cost of auditing a skilled nursing facility at $3,750 per facility if all facilities were surveyed,[2] while Rhode Island officials have estimated the cost at about $1,000 per facility and predicted that such audits "would have surfaced hun-

[2] Statement before the subcommittee of Peter Franklin, Special Assistant to HEW Secretary, July 12, 1975.

dreds of thousands of dollars that would have been owed to the State."[3] A range of enforcement procedures such as periodic fiscal audits by CPAs or systems of graded penalties for infractions, should be considered. The subcommittee notes that H.R. 8733 (see Appendix I), would require the Secretary of HEW to conduct an annual audit of hospitals, nursing homes, and other institutional facilities participating in medicaid, and annual audits of medicare providers of service.

The subcommittee has concluded based on the record before it, that it is not a question of whether nursing homes should be audited, but rather by what means, how frequently, and by whom. Beyond the specific recommendation concerning on-site auditing contained in this report, the subcommittee recognizes the need for further development of regulations and auditing procedures which are effective, fair, and appropriate to the goal of producing the best available care for each Federal dollar spent.

Survey Confidentiality

Many Government surveys such as the Office of Nursing Home Affairs' 1975 Facility Improvement Survey, and many of the State fiscal audits of nursing homes are confidential, insuring the anonymity of the institution being surveyed. The ONHA's survey stressed:

> (a) The research nature of the survey; (b) the assurance that the survey was in no way related to certification surveys for participation in the Medicare/Medicaid program; and (c) the assurance that all data were confidential.

While the subcommittee believes that confidentiality may serve the purposes of insuring wider cooperation and receipt of more accurate information, restriction of access to the names of institutions or nursing home owners may not in many cases serve the interests of the public. The subcommittee believes that the testimony offered points to the need for full public disclosure of major violators. Such disclosure may encourage action that will result in correction of deficiencies and improvements of life safety conditions for residents. Accordingly, the subcommittee will investigate disclosure procedures which allow for greater public accountability within the bounds set by the Privacy Act of 1974 and accompanying regulations which insure individual anonymity and confidentiality.

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[3] Hon. Philip W. Noel, Governor of the State of Rhode Island, July 12, 1975, testimony before the subcommittee.

CHAPTER V

IMPORTANT AREAS FOR FURTHER STUDY IN LONG-TERM CARE

Throughout the subcommittee's investigation and taking of testimony on alternatives to institutionalization, persistent themes emerged which require this subcommittee's commitment to further study. Although often phrased in terms of alternatives to institutionalization, witnesses and experts who served as resources to the committee seem to have implicit in their testimony a question: How would we design a long-term care system to serve our elderly citizens' needs if we could start over again? New initiatives in long-term care, whether experimental in nature or a reflection of tried and proven techniques, are thought to be hampered by the existing categorical nature of programs, inconsistencies in regulations, current staffing patterns, or the like.

The message to Congress is clear. To effectively promote and stimulate positive efforts in this area, Congress must understand the decision-making process in the individual assessment and treatment of elderly persons. Indeed, in certain areas to be outlined below, Congress must not only know how the decision-making process affects the elderly, but also how it affects other non-elderly persons who receive treatment for chronic impairment.

Much of the recent legislation enacted by Congress is predicated on the assumption that increased availability of services will lead to increased access and utilization of services. But the subcommittee has found that more service is not necessarily better service, especially if the potential recipient is not given opportunity to use services, understand what services he may receive, or is not defined as "eligible."

There is also an assumption that increased access to services will lead to better health and the improved welfare of the elderly. Our investigations have shown that the formula for delivery of quality care to the elderly are more complex than these simple equations would indicate.

Testimony given to the subcommittee by diverse groups indicates the need for evaluating the appropriate emphasis to be given to two distinct models of care within the continuum of geriatric health care: (1) the medical model, and (2) the health-social services model. Should the present medically oriented medicaid and medicare programs be continued, or do we need alternate long-term care programs which integrate the social and medical components of care through their programs and regulations? What balance between institutional and non-institutional services would best meet the needs of the elderly? Those are major questions which the subcommittee has begun to address, and it will continue to direct its efforts toward them in the next year.

Issues which will be examined by the subcommittee in this framework include the following:

Long-Term Care for the Mentally Impaired Elderly

The Supreme Court's landmark in Donaldson vs. O'Connor, regarding the rights of individuals who are involuntarily committed to a (mental) institution. The Supreme Court found the case raised a single, relatively simple, but nonetheless important question concerning every man's constitutional right to liberty. The jury had found that Donaldson was neither dangerous to himself nor dangerous to others, and also found that, if mentally ill, Donaldson had not received treatment.

The Court held a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. Since the jury found upon ample evidence, that O'Connor, as an agent of the State, knowingly did so confine Donaldson, it properly concluded that O'Connor violated Donaldson's constitutional right to freedom.

Mr. Justice Stewart's opinion further states:

> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.

In effect, the Supreme Court in its decision emphasized the individual right to treatment or release of persons in such institutions.

Testimony in a September 28, 1975, hearing on Mental Health and the Elderly by the Senate Special Committee on Aging also pointed to the fact that more often decisions were being made regarding deinstitutionalization on the basis of cost than on the basis of the individual rights or treatment availability where geriatrics or mental patients were concerned. Mental hospitals and nursing homes throughout the country are now faced with critical decisions which directly affect the life and health of thousands of patients.

There is no question that older people in institutions differ from a general population of older people. The institutionalized are in an advanced old age (average age of 82 compared to 72 in the general elderly population of institutionalized and non-institutionalized persons combined). They have a high incidence of both physical and mental impairment which hampers their ability to care for themselves, be independent and be active. Studies by Elaine Brody [1] indicate that on the average, elderly persons in long-term care institutions are saddled with four major disabilities.[2] Between 50 and 80 percent of older individuals in institutions have some degree of mental impairment.

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[1] Elaine Brody: "The Decision Making Process In Individual Assessment." Invited Paper, National Council of Social Workers Conference, May 10, 1975.

[2] Among the most frequently encountered problems: heart disease, chronic brain disease, arteriosclerosis and hypertension, diseases of the musculoskeletal system, stroke, fractures, diabetes, and deafness.

Although mental impairment varies widely in its etiology and form of expression, all forms whether diagnosed as "mental illness" or "senility" have some potential for making individuals dysfunctional. However, we also know that with proper treatment *and* individual understanding, the effects of such impairment can be lessened for all populations—including the elderly.

Data and estimates show that there is a disproportionately high number of elderly in mental hospitals: the total population over 65 in mental hospitals range from 28 to 40 percent although the elderly compromise only about 10 percent of the total population. And while there are only about five percent of the total population in all forms of institutions at any one point in time, almost 1 in 4 elderly persons will be institutionalized at some point in their later years.

The prospects are not bright for meeting the immediate and long range mental health needs of the elderly without major initiatives at all levels of government and individual communities. Nathan Slote in the *Handbook of Community Psychiatry and Community Mental Health*, 1974, asserts that should present trends of mental health service continue through 1980, 80 percent of the elderly in need of mental health services will never receive them. On the other hand it is clear that many elderly persons are in mental hospitals not because of severe mental impairment, but because there is no other place for them to go. At present institutional care facilities provide 85 percent of the mental health care received by the elderly. The impact of the Donaldson decision may well be to release additional elderly persons from the custodial facilities such as mental institutions and nursing homes without there being sufficient resources in the community for their mental health or general care and human needs.

The President's Task Force on Aging in 1970 expressed its concern regarding the use of State mental hospitals as custodial facilities for the elderly who are not in need of active psychiatric care because alternative living arrangements and psychological support do not exist. The problem for Congress and the American people as well as for those who are currently providing mental care for the elderly is to develop means whereby the constitutional rights to liberty of the elderly will not be infringed, and their individual needs for protection and care will be met.

For some years the Nation's efforts in this direction have been focused on a consensus: individuals should be confined against their will only to the extent that no other alternatives are available. To put it in a more positive way, State intervention in an individual's life regardless of that person's age or condition must be rigorously limited under strict and definable conditions.

Peter M. Horstman, an expert in the legal aspects of protective services for the elderly defined these conditions as the following:

(1) The individual has been declared mentally incompetent to determine the advisability of seeking or refusing treatment;

(2) Less restrictive alternatives than total institutionalization have been fully explored;

(3) The individual is unable to live safely in freedom either by himself or with the assistance of willing responsible family members or friends;

(4) The individual is untreatable; and

(5) Institutionalization is in the individual's best interests.

Mr. Horstman says that these conditions must be simultaneously present before we impose protective, custodial, or institutional restraints on the elderly. (Missouri Law Review, Spring 1975, pp. 215–278)

The subcommittee believes that intensive study must be made of the relationship between the total mental health and protective services available to the elderly and community or social support which may be available either outside mental institutions and nursing homes or in such institutions. Legislation in this area should stimulate the provision of assistance to the mentally impaired elderly, and should not impose restraints on the ability of the elderly to live in their community unless no other alternatives are possible.

Before study and investigation is completed the subcommittee does not wish to make specific recommendations. However, we feel the following kinds of investigations may yield important results:

(1) The subcommittee will give strong emphasis in the future hearings on individual treatment programs for persons in nursing homes and mental institutions. This implies the development of programs in institutions which will treat severely impaired physically and mentally elderly individuals as human beings. Where the individual has no "alternatives" to institutionalization, he should have some "alternatives" within the institution. Other countries, particularly those in Scandinavia, have set specific nursing home policies and goals which have as their prime goal the treatment of persons in such institutions so as to maximize their individual rights and allow them needed health and social support. Persons institutionalized in these countries are not called "patients" but residents. The goal of treatment is to develop a person's maximum capacity for self care, but where this has definite limits, in any case, to take into account the patient's interest and lifestyle in his treatment plan.

(2) The subcommittee will study the decision-making process in the assessment, placement, and treatment of individuals. It will examine treatment plans and assessment procedures which go beyond the definition of a person's physical, mental, or medical state. There have been successful attempts to assess the individual human and social needs dictated by a person's past lifestyle and future goals. For example, the Philadelphia Geriatric Center uses such assessment in planning a treatment program for elderly residents of its facility.[3] The subcommittee believes that an understanding of these essential priorities in care of the elderly, will lead to the enactment of legislation and promulgation of regulations that stimulate rather than inhibit local community responses to these needs.

(3) The subcommittee will study the patterns of admission and re-admission of elderly patients to mental institutions.[4] There will be special attention given to the role of adequate treatment plan in transfer of elderly persons to nursing homes, other long-term care institutions, or the community. The General Accounting Office is currently studying the role of differing regulatory requirements and former residents of mental hospitals. The subcommittee has discussed the study with GAO, will make use of the findings of that study, and will go beyond it to examine other regulations of programs which affect dis-

[3] See various reports and studies of the Philadelphia Geriatric Center by Elaine Brody, L. Gottesman, M. P. Lawton, et al., 1908–1974.

[4] State legislation such as the Lateran-Petra-Short Act in California, regulating patient placement and admission are being considered as possible methods.

charge and transfer for the elderly (1. Titles VI and VII of the Older Americans Act; 2. Title XX of the Social Security Act; 3. Title XVIII—Medicare; 4. Title XIX—Medicaid). In particular the subcommittee will examine the interrelationship between the regulatory provisions of SSI and medicaid as well as the interrelationship between the so called levels of care provided under definitions of Skilled Nursing (SNF) and Intermediate Care Facilities (ICFs). These regulations will be examined and assessment will be made of how they may be better defined or changed to permit adequate monitoring and evaluation of discharge, planning, referral, transfer, and follow-up.

(4) The subcommittee believes there is an urgent need to study both the inappropriate placement of elderly persons in mental hospitals and inappropriate placement of persons who are severely mentally impaired together in institutions with persons who are faced with more general problems of old age. What institutional facilities offer appropriate environmental supports and treatment for both the mentally impaired and non-impaired elderly? While there have been no national studies of this problem it has been estimated the majority of persons in mental institutions over age 65 are inappropriately placed and treated.[5] In 26 states old age is used as a statutory recognized cause in the definition of mental incompetency.[6] Peter Horstman in testimony before the subcommittee on June 16, 1975, reported a study undertaken by the National Senior Citizens Law Center in October and November of 1974 on guardianship and conservatorship filings in Los Angeles County General District Superior Court. The study showed that of 1,010 cases examined, in 84.2 percent of the cases the only persons present at an incompetency hearing were the judge, the petitioner, and the petitioner's attorney. Physicians were present to testify only about 0.1 percent of the time. The proposed ward himself petitioned to have a guardian in only 12.2 percent of the cases studied and for elderly persons this percentage was even less (7.8 percent). 80.1 percent of the proposed wards were over the age of 60 and only 4.4 percent of the petitioners were denied or dismissed for reasons other than death or disappearance of the proposed ward. In 2.9 percent of the cases where the proposed ward was represented by counsel, the dismissal rate was 34.6 percent.

These data imply that large numbers of elderly in mental hospitals are there because of the inequalities in the commitment procedure itself rather than because of individual needs.

Nursing homes have become a major source for the placement of aged state mental hospital patients. Are these homes appropriate placements for this type of patient? The subcommittee doubts that there has been adequate determination whether individuals released from mental institutions and placed either in the community or in nursing homes receive services which alleviate or change their condition appreciably. The subcommittee will examine (1) institutionalization of elderly persons who do not require institutionalization; and (2) placement of persons diagnosed as having any one of the several forms of severe mental impairment in institutions and congregate

[5] Alexander G. and Lewin T., "The Aged and The Need For Surrogate Management," Syracuse University Press, 1973, Chapter 3.

[6] See "National Association for Mental Health, Inc., Position Statement on Facilities and Services for the Geriatric Mental Patient," December 4, 1971.

care facilities with other persons who have no severe functional or organic disabilities.

(5) There is an urgent need to study the special forms of mental illness that beset elderly populations. Results of studies from the Duke University Center for The Study of Aging, the University of Michigan Centers for Human Development and Geronotology, and other research sources funded by the National Institute of Mental Health, indicate that while one should expect a gradual lessening of abilities with age, *many of the problems of aging result from psychological and physiological distress which is preventable.* One of the major factors which cause the elderly to turn away from society (and society from the elderly) has to do with the reality of death, the loss of friends and immediate day-to-day contacts. Such loss further increases the social isolation that the physical infirmities of old age brings. The Biometrics Branch of the National Center of Health estimates that there are 236 new cases per 100,000 in persons from 35 to 54. A majority of these cases involve severe depression and other forms of involutional disorders. Clearly psychopathology in general and depression in particular rise sharply with age. Suicide reaches its zenith both in elderly white males and females at this time.

It may well be that the use of public mental hospitals and nursing homes to care for the elderly with depressive syndromes may only further exacerbate their problems. There is great potential in this area for the subcommittee to study alternatives to such placement, such as the development of community-based congregate placement that could sharply reduce the incidents of depression in elderly populations which may lead to such institutionalization.

(6) The subcommittee will study means to reduce the isolation of persons who are in mental institutions and to the development of consumer and provider community based visitation terms which will lead to greater community presence in institutions and greater opportunity for elderly persons to move into the community when they are able.

The subcommittee recognizes that there are no simple answers to the questions of deinstitutionalization of the elderly. Indeed, some studies [7] have shown that under some conditions state hospitals are a better place for the elderly than are nursing homes. The subcommittee believes the key to looking at this problem involves a new awareness on the part of Government of a sense of the person—currently missing in our legislation and regulations. Accordingly, the subcommittee's efforts will be directed at formulating recommendations for legislative and programmatic action which give privacy to the individual need for treatment and humane ways of case management and placement.

The Life Safety Code, Regulations, and Quality of Care

In the aftermath of recent findings on nursing home fires and unsafe conditions in long-term care facilities,[8] strict life safety code

[7] Notably Epstein, 1973.

[8] See GAO Report, "Many Medicare and Medicaid Nursing Homes Do Not Need Federal Fire Safety Requirements," Mar. 18, 1975; and Supporting Paper No. 5, "Continual Chronicle of Nursing Home Fires," committee print from the 94th Congressional Session, August 1975, part of "Nursing Home Care in the United States: Failure in Public Policy," Senate Special Committee on Aging.

requirements and regulations were imposed on skilled nursing facilities and other institutions caring for the elderly and disabled. There has been widespread failure to comply with the requirements of that code and failure to enforce provisions of Federal regulations which would result in withholding of funds to institutions who do not meet the life safety codes.[9] This state of affairs is further complicated by changing codes of the National Fire Protection Association. The Association, which is currently responsible for setting the requirements of the code, has at least 3 operative or soon to be used versions of the codes it chooses. The 21st version of the code was drafted in 1967, and the 23rd in 1973. The code is currently undergoing revision and will be published as the 24th edition in early 1976.

Legislation (H.R. 10317) which would update the life safety code requirements for skilled nursing facilities by requiring that the current 1973 version be complied with has been passed as part of H.R. 10284. The Medicare Amendments of 1975 are now Public Law 94–187. This act stipulates that facilities currently qualified under the 1967 or State codes approved by the Secretary will not lose their certification due to changes in requirements specified by the 1973 edition of the code.

The subcommittee intends to study whether the pending 1976 version of the code is more appropriate to long-term care needs. However, *it is more than the differing specifications of such variations in Federal and State approved codes that give State enforcement agencies and individual care institutions problems.* A major problem for State licensing inspectors has been that there is a shortage of beds available, for example, to medicaid recipients. A strict application of the provisions of life safety and other facility standards would result in closure of a large number of homes, thereby creating an even greater shortage of care facilities for the elderly. Closing institutions in the absence of adequate provisions for care of its residents may well do more harm than good. This in turn can lead to an unfortunate tendency not to enforce standards or to create an internal set of standards which may not be reviewable. (These legal and ethical problems of this situation are discussed more fully in Elias Cohen, "Long Term Care: A Challenge to Concerted Legal Techniques," unpublished manuscript, September 1973.)

The Life Safety Code requirements in their present form are oriented toward large institutions. This means that hospitals and large nursing homes are more capable of complying with the kind of institutional standards set by the National Fire Protection Association than are smaller residential and congregate care facilities. There is no question that all homes and institutions, regardless of size, should be made safe for residents. However, by adopting and enforcing standards which tend to eliminate smaller and more intimate care settings, government may be working directly at cross purposes with its intention to deinstitutionalize whenever possible or place the elderly in suitable group living arrangements.

There are problems for the states in trying to conform with the most recent editions (1967, 1973 and 1976 (pending)) for the code. The

[9] The Long Term Care Facility Improvement Study (July 1975, p. 13) of the Office of Nursing Home Affairs reports that only 6.1 percent of institutions surveyed met all life safety code requirements.

subcommittee will explore this question particularly, with the view toward proposing legislation which will permit smaller residential facilities for the aging and ability to comply with life safety requirements.

True "life safety" requirements involve more than fire protection or structural changes in a building. It may be that excessive emphasis on development of regulations centered on one area of life safety, such as fire safety, can lead to de-emphasis on development or companies with regulatory arrangements, which may stimulate increased quality of direct care given to the elderly. Under conditions where resources (both human and financial) are severely limited, the states become faced with an unacceptable either/or situation: either one must limit dollars available for meeting life safety provisions such as those which will maximize the quality of individual treatment or a produce or acceptable congenial environment, or limit enforcement or life safety/fire safety codes.

Certain provisions of the fire safety code are drafted so as to be inappropriate or senseless in certain situations. For example, the Philadelphia Geriatrics Center built a large, open, flexible room for its mentally impaired elderly residents. This room was designed on the basis of the latest findings concerning how to arrange a living environment to meet the special needs of the mentally impaired elderly. In order to conform with the letter of the code, the designers of that room were required to have corridors at least 8 feet wide. Since there were no corridors in this section of the building and since to build walls creating corridors would have destroyed the concept of that living environment, the inspectors and the administrators of the Philadelphia Geriatrics Center finally agreed upon a plan whereby an 8 foot strip of different colored linoleum floor tile was laid down to represent "the corridor."

This anecdote illustrates the weakness in the life safety code with regard to its applicability to the diverse institutions which provide various levels and types of care. The current blanket application of life safety codes on all types of facilities, including those that provide skilled nursing care, intermediate nursing care, and ambulatory care, has the potential for further confusing the issues of placement and treatment of the elderly with those of providing a safe and appropriate place where the elderly can be treated.

The subcommittee will investigate current regulatory practices which may over-emphasize compliance of a physical plant to standards or codes which are not fully appropriate to them. Its scope of inquiry will thus go beyond examination of life safety code, facility accreditation standards to examination of basic priorities for enforcement of existing regulations, and development or streamlining of regulations and procedures that would reduce the bureaucratic burdens on institutions and improve the quality of individual care.

The subcommittee will also explore new ways to provide legislative authorization for imposing a warranty of habitability on long-term care facilities as an alternative to exclusive reliance on codes which emphasize fire safety primarily. The subcommittee will examine regulatory changes needed that will embrace new techniques for providing clear legislative intent on regulations, guidance to the judiciary, and

power to administrative agencies to achieve goals of legislative bodies as they promulgate life safety and quality of care regulations.

In the time when there are limited dollars available both for construction of more modern and adequate facilities for the institutional care of the elderly and/or development of increased resources for individualized treatment, difficult choices will have to be made. The subcommittee will attempt to investigate means which would permit us to put more dollars toward the maximization of the quality of individual care without sacrificing in measurable degree specific safety requirements which bear on physical structures. Clearly there is a need to determine how dollars and resources can best be allocated to permit people to live a safe and active life in institutions as well as outside of them.

Other Areas for Future Study

During the coming year, the subcommittee intends to investigate several additional areas of concern in the field of the health and long-term care of the elderly:

1. Investigation of the reasons for, and possible solutions to, the *escalating cost of medical services to the elderly.* Evidence concerning unregulated construction of hospital and other health facilities will be gathered and its impact on cost evaluated. Consideration of the use of vacant hospital space for outpatient services for the elderly, including preventive care, will be evaluated. Inappropriate patient placement in various modes of care and the high cost of *personal assistance equipment such as hearing aids* are other lines of investigation that will also be included.

2. Issues related to the possibility of *standardizing medicare and medicaid physician house call fees.* Testimony before the subcommittee revealed increasing difficulty in encouraging doctors to make house calls. Where public health programs have varying fees, doctors are less likely to be enthusiastic about making a house call to persons under the lower fee, and this fact has made the situation worse. In New York City, for example, medicaid house calls reimburse $28, while medicare reimburses $11 to $14.

3. Additional questions relating to *nursing homes*: control and management of personal finances of patients, the need for standard categorization of Federally funded long-term care facilities, the quality of long-term care provided in the United States, the feasibility of Federal assistance in the development of home health outreach programs by non-profit and public nursing homes, and other means of improving long-term care for the elderly.

4. *Oversight of Regulations*:

A joint report with the Senate Subcommittee on Long-Term Care will be filed shortly on a unique joint Senate-House oversight hearing on October 28, 1975, on recent HEW regulations. The regulations would allow Federal reimbursement for the first time of unlicensed proprietary home health care.

In the interim, it is clear that new decision-making processes in long-term care regulations must be developed. *The subcommittee intends to investigate HEW's decision-making process in developing long-term care regulations*, including the restrictive impact of HEW

regulations on providers of medical care, and red tape incurred by individuals seeking care.

5. The impact of, and possible solutions to, *cutbacks in state medicaid health services for the elderly*. The Medical Services Administration of HEW informed the subcommittee that over 20 States have announced service cutbacks because of increasing State budget deficits.

At the conclusion of these investigations, the subcommittee will make additional and possibly revised, specific recommendations both to Federal agencies and the Congress.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

In its investigation, the subcommittee found extreme proliferation and fragmentation in both HEW and the Congress concerning the delivery of health services to the elderly, to the detriment of the patient who requires a continuum of care. The subcommittee further found institutional bias both in the Department of HEW and under current health benefits statutes, which is largely responsible for the current inappropriate and unnecessarily costly placement of hundreds of thousands of the nation's nursing home patients.

The recommendations include both incremental and long-range proposals. They focus on the very serious unmet need for home health services for approximately two million chronically ill elderly; the need to reduce inappropriate institutionalization of elderly patients with cost-effective alternatives; the need to develop better methods of assessing long-term care patients; and the need for better methods of referral to the proper level and type of care. While recognizing that there is more to long-term care than nursing homes and home health care, these components are major, and this first report of the subcommittee focuses principally on them.

Recognizing the lack of priority for home health care for the elderly in the Federal health dollar—approximately 1 percent of medicare and medicaid—the recommendations not only suggest extension of current home health benefits under existing and additional programs, but propose innovative alternatives to institutionalization: outpatient clinics specializing in geriatrics, multipurpose senior centers including health and nutritional facilities; elderly day health care centers; community care organizations; mobile health units; and other approaches utilizing a "consortium of partners," where Federal, State, local, and voluntary agencies cooperate in maximizing patient care. The subcommittee has recommended a system of community long-term care centers to coordinate the provision of health services for older Americans in order to provide linkage in the current fragmented delivery system.

The subcommittee believes the present acute-medical orientation of the Nation's health policy, largely based upon compromises in the 1965 medicare and medicaid statute, should be changed. A preventive and medical-social model needs to be developed to avoid later costly curative care and to allow the elderly to be productive in the community.

The subcommittee seeks greater administration and congressional attention to health maintenance programs and recommends an annual health fair in communities, medicare and medicaid amendments providing annual physical checkups for persons over 60, and other health maintenance and health education programs.

The subcommittee has suggested means of assisting elderly patients to know what benefits are available to them. The establishment of a

home health clearinghouse is recommended to disseminate and collect information on existing Federal, State, local, and voluntary home health benefits and programs.

The subcommittee has also suggested major reorganization of HEW health programs, including the creation of an Assistant Secretary for Elderly Health, and the removal of the chairmanship of the Interagency Home Health Task Force from the Office of Nursing Affairs due to the structural conflict of interest.

The subcommittee considers of major importance the creation of a new House Committee on Health, necessitated by the impact of the split-jurisdictional problems in current national health insurance and other health legislation between Ways and Means, Interstate and Foreign Commerce, Education and Labor, and other committees. While the subcommittee is aware of the political difficulties of such a proposal adjusting jurisdictions, it felt that unity and rationality in health planning are paramount and that a single united committee, with initial membership drawn from the current committees with health expertise, is a sensible solution to the current jurisdictional dispute over national health insurance. As an interim solution, the subcommittee has strongly urged the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce to hold joint rather than separate hearings on that subject.

The subcommittee found a "dearth of audits" of nursing homes—20 States have not audited a single medicaid nursing home since 1967—and found that hundreds of thousands of dollars had been inappropriately spent in those that had been audited. The subcommittee has recommended Federally supervised, unannounced, on-site audits of nursing homes receiving Federal funds under medicare and medicaid. In addition, the subcommittee states its intention to investigate the reasons that 93.9 percent, according to HEW, of the nation's nursing homes do not comply with the Federal Life Safety requirements—is the fault in the Code, the homes, or both? The subcommittee also plans to investigate institutionalization of the mentally impaired elderly and to study other important issues in long-term care of the elderly.

Alternatives within the recommendations regarding home health care and innovative alternatives to institutionalization are offered to furnish each of the legislative committees and subcommittees with jurisdiction over the particular matter the fullest possible range of legislative options to accomplish the goals cited in the report.

The subcommittee hopes that the Congress, the Department of Health, Education, and Welfare, and other appropriate agencies will consider the recommendations in determining future directions in health care for older Americans. The proposals are intended to open honest and thoughtful debate on questions of public policy. It is hoped that the recommendations will lead to alteration of the fragmented approach of the past, which has kept hundreds of thousands of older Americans inappropriately institutionalized and has denied to still others adequate health care.

RECOMMENDATIONS

[Both incremental and long range policy changes are recommended below. While the subcommittee believes that the creation of community long-term care centers (Recommendation No. 1) is of vital importance in providing a continuum of care for the elderly, it recognizes that the Congress must thoroughly analyze the financing and administrative ramifications of this proposal before enactment of this process, which will be time consuming. Therefore, interim recommendations are also offered that would be implemented immediately as part of the existing health care framework.

[The subcommittee has made specific recommendations below to end the proliferation and fragmentation of Federal health programs, both by congressional and statutory consolidation. However, because recommendations such as the proposed new, united Committee on Health are not yet enacted, and because health statutes are accordingly not consolidated, the subcommittee has also offered recommendations which recognize the current situation.

[As stated earlier, alternatives within the recommendations regarding home health care and innovative alternatives to institutionalization are offered in order to furnish each of the legislative committees and subcommittees with jurisdiction over the particular matter the fullest possible range of legislative options to accomplish the goals cited in the report. The subcommittee is hopeful that the chances of enactment of these important goals will thereby be enhanced.]

I. PROLIFERATION AND FRAGMENTATION: A NATIONAL PHENOMENON

(1) Legislation such as H.R. 1354 (See Appendix I), the Medicare Long-Term Care Act (also H.R. 2268, H.R. 10908, and S. 2157) should be enacted to create a *system of community long-term care centers to coordinate the provision of health services for older Americans* suffering from chronic illness or disability. Services would include home health services, homemaker services, nutrition services, long-term institutional care services, day care and foster home services, and a community mental health center for outpatient services. These services would be made available through community long-term care centers which would coordinate and direct the long-term care services. Such centers would be planned and developed under the aegis of the States' health and social welfare functions, allowing State eligibility for Federal grants.

The long-term care centers would provide local linkage among providers in the otherwise fragmented delivery system and would provide greater flexibility in assigning persons to different care settings.

The subcommittee believes that the elderly must have the right to high quality care in the setting of their choice, subject to utilization review and appropriate standards and guidelines. Under this legislation, the long-term care center team, working closely with the patient, would be able to provide the patient this choice.

The center would evaluate and certify older Americans' needs for services through a team composed of individuals with the skills necessary for such evaluation and certification. The care prescribed would be based on the maintenance of an individual in an independent living arrangement if reasonable, given the individual's state of health and other circumstances. Hospitals, skilled nursing facilities, or home health agencies would be considered to have a transfer agreement with a community long-term center when such transfer is deemed medically appropriate by the attending physician. Interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between such hospitals and other facilities is provided for in determining whether patients can be adequately treated outside a hospital or skilled nursing facility.

The legislation would also provide that a community long-term care center shall not certify the need for inpatient institutional services for an individual unless a determination has been made that the needs of such individual cannot be met through the provision of the services covered under the bill's alternative benefits to institutionalization or other community resources available to such individual.

Legislation should also authorize grants to colleges, universities, public agencies, and nonprofit private entities to develop models for more flexible patient assessment in public health policy, with special emphasis on means to avoid placement in inappropriate levels and modes of care.

(2) *A new House Committee on Health* with exclusive jurisdiction over medicare, medicaid, national health insurance, health aspects of the Older Americans Act, and health care legislation in general.

In its hearings on health services for Older Americans, the subcommittee found a majority of needed health legislation to have overlapping jurisdiction in the Congress. Most major national health insurance, home health, nursing home reform and other health proposals were divided between the Ways and Means Committee and Interstate and Foreign Commerce Committee because of the jurisdictional division between medicare, medicaid, and other health programs. The House Parliamentarian's office has termed such health bills referrals "a nightmare."

The subcommittee agrees with the report of the Select Committee on Committees of March 21, 1974, which states:

> Consolidation of the jurisdiction now divided between these two Committees (Ways and Means and Interstate and Foreign Commerce) would bring greater rationality to the question of supply and demand in health care needs.

In addition, a Select Committee on Committees' staff report of September 12, 1973, pointed out, "Medicare and Medicaid have not been closely coordinated with programs such as health personnel training."

Also, the Older Americans Act provides health services to many elderly citizens who would be covered under various national health insurance bills.

Both the Ways and Means Committee and the Interstate and Foreign Commerce Committee are currently conducting hearings on national health insurance. We find the provision of adequate health care of paramount importance to the American people. As an interim measure *we hope and recommend strongly that these two committees join forces on this issue.* The current division and duplication is especially unfortunate for the elderly citizen in need of health care. While we encourage the committees to unite in these current investigations, we believe that *the only way to guarantee future rational health planning is to create one committee with exclusive jurisdiction.*

Because of the expertise developed by members of the subcommittee with current jurisdiction over health questions, we recommend that initial membership in the new committee be drawn from these subcommittees of the following committees in the following proportion: *six* from the Committee on *Interstate and Foreign Commerce* (Subcommittee on Health and the Environment), *six* from the Committee on *Ways and Means* (Subcommittee on Health), and *three* from the Committee on *Education and Labor* (Subcommittee on Select Education).

(3) *Legislation to create a comprehensive Home Health Clearinghouse within the Department of Health, Education, and Welfare to gather and disseminate information concerning the various public and private agencies providing home health care and correlative services to the elderly.*

Throughout the subcommittee's hearings, the message rang over and over that with the extreme proliferation of programs, the elderly need a place where they can obtain information on the health programs available to them.

The proposed clearinghouse would serve this function. The national clearinghouse will collect information on Federal, State, local, and private services and would assist in information referral to organizations, agencies, and patients by providing input to local community locations.

The Home Health Clearinghouse will establish a computer network feeding into the 1,200 branch and district social security offices that are *already* equipped with a two-way "turn around" computer system for cash benefits evaluations; and as many as possible of the following locations, convenient for senior citizens: the total of 4,500 social security district offices, branch offices, and regularly scheduled service locations; the 487 area agencies on aging; the over 3,000 local welfare offices; the 4,900 senior centers (1,600 receive Federal funds); and other public or voluntary agencies. The Social Security Administration's established computer system for various benefit programs is generally considered the "world's largest record keeping operation." While there will be human error in an undertaking of this extent the services would be worth the predictable error ratio.

The immediate information availability could be invaluable for the potential health service recipient who is now shuttled from office to office, never certain he has obtained maximum allowable relief.

The computer network would both protect the beneficiary's privacy and yield virtually instantaneous criteria to the caseworker. The information (but *without the recipient's name*) would be fed into the computer system so as to protect anonymity. *The recipient would*

shortly be provided a printout of the exact Federal, State, and local outpatient and home health benefits he or she qualifies for, a list of whom to contact to obtain them and if possible a list of voluntary agency benefits and contacts for his or her particular situation as well.

The clearinghouse would also be given the responsibility of preparing an easy-to-read manual, entitled "Federal Home Health Services for Older Americans." The manual should describe the available Federal home health, clinical, and other outpatient benefits under medicare, medicaid, the Older Americans Act and other programs; the eligibility criteria; the overlap among programs; and offices one should contact for additional information or to confirm eligibility for the various programs.

The manual could be modeled after the excellent one published in May 1975 on title XX, "Social Services '75—Program Options and Public Participation Under Title XX of the Social Services Act: A Citizen's Handbook."

The clearinghouse should be established immediately, so as to begin determining the correlation between the various programs, to publish the manual as soon as possible, and to establish *initial* computer outlets. The legislation should provide that HEW investigate the *cost* of the computer network aspect to determine the feasibility of *full* dissemination and report the findings to the Congress within 1 year.

In creating the clearinghouse, HEW should take into account the current clearinghouse function of the Area Offices on Aging, as well as the informational systems of the Social Security Administration, and HEW may place the Home Health Clearinghouse in either of these organizations or elsewhere in the Department. In addition, HEW should be required to upgrade its present computer systems (such as those of SSA), to insure they are first used to their full capacity for the new Home Health Clearinghouse (but without impairing their other functions) when establishing the new networks.

II. Home Health Services: A Right to Choose

A. LEGISLATIVE RECOMMENDATIONS

(4) *Major reorganization within HEW to correct the structurally-based institutional bias of the Office of Nursing Home Affairs' coordination of the Interagency Home Health Task Force.*

The subcommittee recommends that the Department create, directly under the Secretary, an *Assistant Secretary for Elderly Health*, to be the focal point for the coordination of Departmental policy for the health of the elderly, and *to have ultimate "line," authority and responsibility* (except for the Secretary) *over all health and health-social matters for persons over 60* under medicare, medicaid, the Public Health Service Act, and other relevant statutes, regulations, and Departmental policy directives.

The new Assistant Secretary for Elderly Health will coordinate interagency task forces on long-term care, both in the home health area and in institutional care. The Office of Nursing Home Affairs' coordination of the current Interagency Task Force on Home Health should immediately be terminated.

The Assistant Secretary for Elderly Health would also have responsibility for health financing and reimbursement for persons over 60. Other Departmental officials (excepting the Secretary) working on

other health areas would obtain the Assistant Secretary for Elderly Health's approval for policy regarding health financing and reimbursement of the elderly.

The subcommittee recognizes that there are differences in current programs that would be brought together under the proposed Assistant Secretary—particularly between purely acute medical services and health-social services under the Social Security Act. However the subcommittee is convinced by the depth of the testimony before it that the current fragmentation must be ended both among the purely medical programs and between medical and health-social programs. Implementation of the recommendation would be a step toward developing continuity in programs that can maintain the elderly as healthy and productive citizens in the community.

(5) *Additional appropriations for grants and loans for nonprofit and public home health agencies and for the training of professional and paraprofessional home health personnel.*

The House-passed Supplemental Appropriations bill, H.R. 10647, appropriated $3 million of the $10 million authorized under Public Law 94–63, amendments to the Public Health Services Act.

The subcommittee recommends that the home health grants program under Public Law 94–63 be appropriated to the full amount, and be extended beyond its current 1-year period. The subcommittee recommends an increase in this program in fiscal year 1976, with a grant and loan program administered by HEW providing $10 million in grants and $10 million in loans for expansion of services by existing agencies; and $20 million in grants and $20 million in loans for the development of agencies in underserved counties and counties not served at all by certified agencies. The subcommittee believes that the projected $60 million total would be extremely *cost effective* in view of the $118 billion spent on health care in the United States in 1975 including *$9 billion on nursing homes and over $41 billion on hospital care.*

The program should include grants to colleges and universities to train or retrain guidance counselors, social workers, registered nurses, and other geriatric specialists in the home health needs of the elderly, and for the inclusion of gerontology in existing programs in counselor education, nurse training, and social work programs. The scope of the training should emphasize maintaining the elderly individual in the home and community environment and should transcend purely medical areas by emphasizing the related sociological, psychological, and supportive needs of the individual.

Furthermore, the Department of HEW should immediately develop procedures for use of the home health funds appropriated under Public Law 94–63.

(6) *Legislation should be enacted to expand home health benefits under Medicare and Medicaid, providing eligibility to more people in need of health services and allowing additional services as necessary to provide a true comprehensive alternative to often inappropriate and costly full-time institutionalization.*

The subcommittee recommends legislation to accomplish the following:

Add a full range of *homemaker and other correlative services* to medicare's current coverage of doctor and nurse visits. Specifically

provided would be assistance in household tasks, shopping, walking, transportation to and from doctors' offices and senior centers, personal and vocational guidance, and such other services as deemed necessary by the Secretary of HEW to maintain an individual outside an institution. Also, provide *medical supplies* (including prescription drugs and biologicals), the use of medical appliances, and other sickroom supplies which would have been provided if the individuals were receiving institutional care.

Removal of the confusing and restrictive "skilled" nursing requirement for obtaining home health benefits. Use of this term, which the doctor and intermediary (generally the insurance company) often disagree on *after* the doctor prescribes and the patient receives services, has largely been responsible for retroactive denial of reimbursement to the patient. (See GAO Report, "Home Health Care Benefits Under Medicare and Medicaid, July 9, 1974.") Furthermore, services which are not "skilled" are often critical to keeping a patient outside a full-time institution.

Require States to include the *full-range* of medical and supportive home health services in order to qualify for Federal *medicaid* funds.

Permit State medicaid programs to cover payment of rent or mortgage, repairs, and property taxes for elderly or disabled persons who would otherwise require nursing home care. While initial implementation of this program may be difficult in some cases, the fact that it is optional, together with the incentive of matching funds, will encourage those States which are able to do so to develop a broader alternative to institutionalization. It should be noted that all living costs are covered in hospitals and nursing homes.

Require disclosure for all medicare and medicaid nursing homes and home health agencies, of any persons with ownership interest in the home or agency, or in the land or building housing the home or agency. Also, require disclosure by nursing home or home health agency owners or operators of any interest in businesses providing goods or service to nursing homes or home health agencies.

Provide for any additional funding needed, if any, from the general treasury rather than impose on the patients themselves any higher premium, deductibles, coinsurance, and payroll tax.

The subcommittee notes that H.R. 10422 (See Appendix I) now pending in the Congress, achieves most of the above goals, which the subcommittee finds are needed to avoid inappropriate institutionalization. However, while there are sections of H.R. 10422 relating to the number of allowable home health visits, delivery of home health by hospitals, and utilization of prudent buyer methods by home health agencies and nursing homes, the subcommittee recommends the following new legislation to clarify and improve those sections and new legislation to cover additional needed areas:

The 100 home health visit limits of both medicare part B (which requires no hospitalization) and part A (post-hospitalization) should be removed. The two parts should be combined, with no hospitalization required for either.

Current law requires medicaid nursing homes to utilize cost-related prudent buyer methods of purchase, so as to reflect reasonable costs. The subcommittee recommends expansion of this requirement, to provide uniformity among other long-term care providers, so that *med-*

icaid and medicare home health agencies and nursing homes should all be required to utilize cost-related methods of purchase. In addition, *the Secretary of HEW should be given the power to cut off unreasonable funds if he finds noncompliance.* (See later recommendations covering nursing home auditing.)

While H.R. 10422 provides for patient referral to the appropriate level of care, the bill only specifies home health services. Recognizing that many high disability patients do require full-time institutional care and that in such cases home health may be more expensive, the legislation states that Federal payment for home health services will not exceed reimbursement that would have been made for skilled nursing facility care; the individual can pay the difference himself or enter an institution if home care exceeds skilled nursing care.

The subcommittee believes that it would be unfair to the patient to cut off funds and possibly force entry into a nursing home if home care costs exceed projected nursing home costs. Such cost estimates in advance would be difficult at best. A cutoff of funds later would create worse "retroactive denial" situations than those even caused by the current reliance on the criteria of "skilled" care, with problems not only in reimbursement but in the transfer to nursing homes of patients that had been led to believe they could remain in their own homes. The legislation would be improved by providing for prospective reassessment of the need for home health care vis-a-vis institutional care, by the three-member panel already provided for in the legislation, after any month in which reimbursement for the patient's care exceeds the cost of skilled nursing facility care.

The subcommittee believes, however, that *patients should be provided a continuum of care*, without the threat of a cutoff of funds for particular services at a specific point.

While the Government should not pay for inappropriate care, a stated or implied obligation to the patient should not be cancelled later.

The subcommittee, therefore, finds that H.R. 1354 (and similar legislation), which provides that *community long-term care centers would coordinate the provisions of a wide range of services*, is more effective in this important area of allowing a continuum of care. (See Recommendation No. 1.)

Mandate *reimbursement for home health services* under medicaid *by persons who are eligible for medicaid intermediate care nursing homes* in those States which permit medicaid reimbursement for intermediate care. Testimony before the subcommittee demonstrated that the sad irony of this omission is that "those are the people who are most likely to benefit by it, because those are the ones who do not need 24-hour nursing home services, and who are largely able to get along on their own." [1]

Medicare and medicaid should be amended to allow *reimbursement for periodic chore services for individuals who would otherwise require full-time institutional care.*

The subcommittee believes that provision of home chore services in instances where the patient would otherwise be in a hospital or nursing home would be *cost effective* and far better for the patient.

[1] Herb Semmel, Center for Law and Social Policy, testimony before the subcommittee, June 16, 1975.

Specific services would be determined in regulations of the Secretary and could include light household repairs, laundry, shopping, advance meal preparation where the individual would only have to "put it on (or off) the stove," help in personal grooming and similar assistance.

To make certain abuse would not occur, PSRO's or other appropriate utilization review mechanisms should be mandated.

Medicare and medicaid should be amended to provide mechanisms for preventive health care to insure maximum health maintenance. The subcommittee heard numerous expert witnesses point to the effectiveness of early detection of disease in the prevention of later costly, long-term illness and disabilities.

The subcommittee recommends that at a minimum, the following services must be provided:

A yearly annual physical checkup for persons over 60 who are eligible for medicaid, and for all persons eligible for medicare (over 65), so that developing disabilities might be detected early; *diagnostic services*, under regulations of the Secretary, including laboratory work and radiology; and health screening.

Medicare and medicaid should be amended to *include, as a home health service, nutritional counseling* provided by or under the supervision of a registered dietician. While hospital and nursing home patients receive such care, the subcommittee believes that nutritional counseling is equally needed for home health patients to assist in long-term health maintenance. Such legislation for medicare has been introduced in the Senate (S. 2547).

Amendments to medicare and medicaid to permit from *1 to 3 hours per week of professional guidance and counseling for the elderly sick and disabled who are living alone at home;* (and an amendment to the *Older Americans Act* to establish community-based programs providing from 1 to 3 hours per week of professional *guidance and counseling for the families of the elderly sick and disabled, with emphasis on the families of individuals who are entering, residing in or leaving skilled or intermediate nursing homes.*)

Amendments to medicare to mandate provision of hearing aids, *podiatry, dental care including dentures and the extraction of infected teeth, glasses*, and other sight aids. The subcommittee considers these services, which are not provided presently except by option of some States under medicaid, as necessary for functional living. The subcommittee also recommends that *hearing and sight examinations* be covered for medicare recipients.

In view of the skyrocketing cost of hospital care (the average cost per bed per day is now over $128, according to the American Hospital Association), and because of the advantages to the patient of a skilled team approach, hospitals should be encouraged to develop outreach programs in the community by allowing *reimbursement to accredited hospitals for health and supportive services delivered to the home* of medicare and medicaid patients, particularly for post-hospital care. Despite the obvious care advantages of continuity of care from hospital to home, home health services are now reimbursed only when services are performed by medicare and medicaid home health agencies. Testimony from hospitals has emphasized the need to avoid the red tape of home health certification for accredited hospitals which can assist patients at home with qualified health providers.

The medicare provision that home health care must be provided "under the supervision of a physician" should be amended to be "by the appropriate health professional, under regulations of the Secretary."

Quality could be assured by legislation *requiring professional standards review (PSRO's) for long-term care*, also *by the appropriate health professional* under regulations of the Secretary. PSRO's should always include a physician, but should also include, as appropriate, a nurse, a social worker, a guidance counselor, and/or other expert. *Under current law, PSRO's are required for hospital services but not for long-term care*, and PSRO's are specifically limited to doctors, with "advice" from other health professionals. In addition, the legislation should direct HEW to promulgate regulations providing that PSRO's review not only the cost, but the quality of care received by patients.

In any *national health insurance program, comprehensive home health care as outlined in all the above recommendations should be included.* If medicare, medicaid, the Older Americans Act, or other home health programs mentioned are replaced by a national health plan, the specific legislative references will not apply, but the provisions cited should be included.

(B) ADDITIONAL RECOMMENDED LEGISLATION

(7) An amendment to the Legal Services Corporation Act to provide *legal counsel* for the elderly sick and disabled who have reasonable cause *to appeal HEW decisions* against the patient's receiving benefits under established programs in medicare (middle and low income persons only), medicaid, or title XX of the Social Services Act *for home health and other programs for avoiding institutional care.*

While legal counsel for the elderly is now possible under the Older Americans Act, it is not guaranteed for persons who may require it. The American Bar Association's Committee on Legal Problems of the Aging has testified, "Without such representation all such proceedings are suspect and perhaps fundamentally defective." [2] Under the proposed legislation, all persons who believe they have been treated unfairly regarding eligibility for institutional alternative programs listed above will have the right at least to a determination of "reasonable cause," and if "reasonable cause" is agreed to, counsel will be provided.

(8) Legislation *amending title XX of the Social Security Act, the new social services program* under a 75 percent—25 percent Federal-state matching arrangement, *to provide further financial incentives to maximize No. 4 of the program's five objectives: "to prevent and reduce inappropriate institutional care as much as possible by making home and community services available."*

Information provided by the Department of HEW indicates that, of the 51 states and the District of Columbia, 40 are not utilizing the full entitlement even though authorized by Congress.

The committee recommends that States which have used up their allocation may submit plans for an additional 10 percent restricted to

[2] Testimony before subcommittee, Ed Krill, Vice President, American Bar Association Committee on Legal Problems of the Aging, June 16, 1975.

use toward goal No. 4, if they have the ability to provide matching funds to implement those plans. The *funds will come from unutilized funds of the previous year in other States.*

Such funds must be additional to the State plan, which already must include at least one service under goal No. 4.

The subcommittee believes that such a financial incentive will provide further encouragement for States to develop plans to utilize their full allocation as authorized by Congress, and that such a financial seed incentive will encourage the development of badly needed appropriate alternatives to institutionalization, alternatives which can cost the government less in the long run and which are far better for the patient.

(9) A series of *demonstration and pilot projects* to determine the effectiveness of various home health and supportive services:

A demonstration project under which current nursing home residents and their families would be provided the funds to finance the patient's care at home. The goal of the project would be to determine the economic, medical, psychological, and sociological feasiblity of transfer of nursing home patients back to their own homes where both the patient and the family so desire but have been prevented for reasons of finances and/or burdensome patient care. The experiment should provide regular monitoring by a registered nurse or other appropriate health professional. The experiment should also attempt *to determine what percentage of nursing home patients could effectively live at home, and what types and percentages of patients would benefit economically and qualitatively from transfer back to the home setting compared to care in the nursing home.*

Programs to *encourage older persons to make periodic visits to other elderly persons who are chronically ill and living alone.* The subcommittee believes that such a program would have significant psychological impact on the lonely, ill elderly. In addition, such a program could provide employment for elderly retired persons. While this program and the following one are already possible under some Federal programs, such as ACTION, testimony before the subcommittee demonstrated a need for expanding such programs.

A demonstration project to determine the feasibility of personal and maintenance assistance of elderly individuals in their own homes by "a neighborhood family," where the care would be provided by two or more individuals related to each other and whom the elderly persons would consider geographically and sociologically in his or her neighborhood.

Experimental programs in five communities selected by the Secretary of HEW to provide disabled persons over 65 *taxable "long-term care vouchers,"* to be spent on any of an approved list of health goods and services. The goal of the experiment is to determine the impact on the health and well-being of elderly patients in an unrestricted market, under freedom of choice by the patient, and with a diminishing of the oversight role of the government on the actual choices of care by the patient.

Pilot programs under the Older Americans Act to provide *home services to the terminally ill of low income* so that patients can die in the dignity of their own homes, rather than in institutions, if at all possible.

(C) RECOMMENDATIONS TO HEW

(10) A major effort by HEW to *publicize the availability of home health benefits* through a radio, television, and press public service announcement campaign. Patients, doctors, and other health providers should be informed of potential patient benefits.

In addition, regulations should be promulgated requiring similar outreach programs by states to medicaid participants.

(11) An HEW *informational program on health maintenance for older Americans.* The pamphlet could be distributed to churches, community programs, businesses, and, upon request, directly to families. Suggestions should be made concerning guidance in nutrition, exercise, proper care of the body, a positive mental outlook, the need for physical checkups, and other appropriate activities.

(12) HEW should follow through on the July 9, 1974, GAO report [3] to the Congress stating that there is "*confusion by intermediaries and by beneficiaries of the coverage provisions.*" GAO called for "more effective and uniform interpretation of existing instructions to intermediaries and home health agencies regarding the various coverage requirements for home health services."

Such confusion and inaction was found to be largely responsible for the low rate of use of available home health services.

(13) Clearer channels of information between top officials of HEW and Departmental Staff, and a *realistic, open-minded attitude by HEW toward home health* legislation, especially those provisions which would *implement the recommendations of the 1971 White House Conference on Aging* (See p. 25).

III. Innovative Alternatives to Institutionalization

(A) OUTPATIENT CLINICS SPECIALIZING IN CARE OF THE ELDERLY

(14) The subcommittee recommends comprehensive legislation utilizing a variety of Federal statutory and program options to *establish and expand outpatient clinics specializing in but not necessarily exclusively for geriatrics.*

Legislation is needed to amend the Public Health Services Act (Section 314 (d), Comprehensive Public Health Services, and P.L. 93–641, the National Health Planning and Resources Development Act, providing "*Hill-Burton*" *funds*) to target a *minimum of $150 million* additional *over 3 years* ($390 million is now provided, but for other purposes with no emphasis on geriatric needs) *for the modernization, construction, and conversion of medical facilities for outpatient clinics specializing in care for the elderly.* The subcommittee believes that $150 million for such construction and conversion, while not adequate to establish an entire national network of clinics will nevertheless begin to meet the need and will encourage state and local governments to take similar steps. Such clinics would provide a combination of primary medical (preventive, interventionary and referral); dental; opthalmic (vision); speech; otologic (hearing); podiatric (foot); rehabilitation; mental health; and health education services. Preventive services such as physical checkups and minor medical services would be provided to

[3] GAO Report, "Home Health Care Benefits Under Medicare and Medicaid," July 9, 1974.

attempted to prevent the later necessity for many elderly persons to be hospitalized or institutionalized.

Fifty percent of the funds would be provided to clinics operated by *hospitals* and *50 percent* to *freestanding clinics.*

The goal of this program is "*one-stop*" *health service for the elderly*, where they can obtain all their health care needs.

Such outpatient clinics which may also be termed "*Home Health Care Centers*," should be located in places easily accessible and familiar to the elderly—churches, union halls, settlement houses, community rooms in elderly housing units, senior centers, etc. The goal is to establish the programs in locations that are "visible, accessible, comfortable, and comforting." [4]

Legislation directing that the Secretary of HEW give priority in project grants for *Community Health Centers under Section 330* of the Public Health Services Act (recently extended by Public Law 94–63), to applicants who propose *to establish outpatient clinics* with specialization in elderly care in areas determined to be of medical underservice.

States should be required to include *freestanding clinic services under medicaid.* This is currently optional.

Legislation amending the Public Health Services Act Amendments, Public Law 94–63, to target a minimum of *5 percent* of title I (*Health Revenue Sharing*) funds received over the next 5 years for the establishment and operation of outpatient clinics specializing in the care of the elderly in underserved areas, 50 percent of such funds for clinics associated with hospitals and 50 percent for freestanding clinics.

Legislation amending Title XI of the National Housing Act, providing mortgage insurance for the purpose of constructing medical group practice facilities, *to require the Secretary to give special emphasis to mortgage insurance for outpatient clinics specializing in elderly care.*

Legislation providing *medicare reimbursement* for *services provided by certified outpatient rehabilitation centers regardless of their connection with a hospital.* The subcommittee notes that S. 2506, pending in the Senate, would accomplish this end. *Currently, hospitals can be reimbursed* for all services included in part B of medicare, *but outpatient rehabilitation centers that are not part of a hospital—even if certified as providing equal care standards—can be reimbursed only for physical and speech therapy.*

An amendment to *medicare* is needed to give the Secretary of HEW power to *reimburse deductible and coinsurance fees to hospitals providing inpatient services for patients referred by* (*and, at the time, under the care of*) *nonprofit, comprehensive outpatient centers who do not require such fees.* The Secretary may expend such funds if, in his determination, the transfer arrangement between the outpatient center and the hospital is saving Federal money that would have been spent on more expensive long-term institutionalization.

The goal of this program is to allow nonprofit comprehensive outpatient centers like the Minneapolis Age and Opportunity Center (MAO) to have successful working arrangements with hospitals when inpatient care becomes a necessity. MAO works with a "consortium of

[4] Rose Dobrof, Legislative Representative, National Association of Social Workers, subcommittee hearing, November 19, 1975.

partners" (see Home Health section of report), provides a comprehensive continuum of care on a sliding scale fee schedule, and free in some cases. The cost is a fraction of that of separate care facilities, and the combined services often prevent unnecessary institutionalization in hospitals and nursing homes or retard such institutionalization.

Legislation commemorating the Minneapolis Age and Opportunity Center as an excellent prototype for other outpatient senior centers, and appropriating $500,000 to the Center for a demonstration project of collating relevant information on its method of operation and disseminating these materials to State Health Commissioners, State Commissioners on Aging, and other interested parties across the country.

Medicare and medicaid should be amended to *reimburse the cost of transportation for* the disabled, and for those over 60, *to and from outpatient clinics.*

Legislation authorizing $10,000,000 for demonstration projects increasing the outreach capabilities of existing nonprofit outpatient clinics specializing in care of the elderly by the *development of* related *mini-clinics* located in nearby cities and counties.

Providers of free space for non-profit outpatient clinics specializing in geriatrics should be granted a *tax deduction* equal to 50 percent of the fair market rent.

(B) MULTIPURPOSE SENIOR CENTERS

(15) The subcommittee recommends that the establishment and operation of *multipurpose senior centers providing basic service assistance in health, nutritional guidance, recreation, and social endeavors should be encouraged by a variety of Federal statutory and program options.*

Authorization of a *specific sum, a minimum of $100 million the first year,* in grants, mortgage insurance, and loan guarantees, *under title V of the Older Americans Act* for the acquisition, alteration, renovation, initial staffing and operation of multi-purpose senior centers with a requirement that they include health and nutrition services as well as recreational and social facilities. The legislation has previously been "such sums as necessary." As no funds have ever been appropriated for this program; the subcommittee believes that a specific authorization would be an important first step.

The subcommittee recommends that *50 percent of the funds* be authorized for the *construction* of such centers and *50 percent* for their *operation.*

In addition, the subcommittee recommends the *actual appropriation* of $100 million under Title V for multipurpose senior centers as defined above.

As a financial incentive, title I, Section 105, of the *Housing and Community Development Act should be amended to provide a 10 percent bonus to add to those funds which communities plan to use for multipurpose senior centers.* The bonus will apply only if the center includes health and nutritional services, as well as recreational and social. A HUD survey of 200 communities has shown that only 17 were planning to use a portion of their funds for senior centers.

An amendment is needed to Section 231 of the National Housing Act, mortgage insurance for construction of elderly or handicapped

living units, to allow *mortgage insurance* for elderly *day* facilities as well in order to provide financial incentives for *multipurpose senior centers* (with health, nutrition, recreational, and social facilities).

An amendment to *title XX of the Social Security Act*, the social services amendments, to provide additional incentives for the establishment and operation of multipurpose senior centers, including health, nutrition, social, and recreational services, *by permitting* a 10-percent bonus *in matching funds* for senior center programs if the State plan includes the funding of senior centers. An HEW survey of the proposed State plans indicates that 22 States planned to fund recreation centers in 1975, and the subcommittee believes that additional incentives would encourage the inclusion of health and nutrition facilities.

Providers of free space for nonprofit and public senior centers providing health, recreational, nutritional, and social facilities should be granted a *tax deduction* equal to 50 percent of the fair market rent or property tax on the actual space used.

(C) COMMUNITY CARE ORGANIZATIONS

(16) Legislation authorizing $15 million in *demonstration grants* under the Public Health Services Act *to* increase the number of nonprofit Community Care Organizations as alternatives to institutionalization, *and* to provide *for the development of related satellite projects* in additional sites. Community Care Organizations shall be defined as a health and health-related organization serving a minimum of 50 percent of clients over 65 and providing a package of home care services including Meals on Wheels, homemaker, home maintenance, snow shoveling if necessary, lawn mowing and other gardening; and medical and health-related services, including physical therapy, visiting nurses, guidance and counseling, social workers as needed and physicians.

(D) ELDERLY DAY HEALTH CARE CENTERS

(17) The subcommittee recommends legislation assisting in the further development of non-profit and public elderly day health care centers, where health professionals perform identical or similar services to those by participants in skilled nursing homes and intermediate care facilities, under regulations of the Secretary of HEW [5] governing quality and scope. Such programs should emphasize interim treatment for persons who have been institutionalized, so as to encourage leaving the institution, full recovery, and a return home.

Medicare and medicaid should be amended to authorize reimbursement for health and supportive services for the elderly received in elderly day care centers as described above. The Secretary should issue regulations of definition within 3 months of enactment of this legislation.

The statutory *requirement for "minimum but continuous care" under the HUD Section 232 of NHA Mortgage Insurance Program for Nursing Homes and Intermediate Care Facilities should be repealed for certified day health care services.* Currently, the SNF or ICF is allowed to have a day care center, but it can only use 10 percent allowed for "commercial space" for that *purpose.*

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[5] See Federal Register, Jan. 9, 1976, p. 1603, for new regulations governing day care contracts.

(E) HEALTH FAIRS

(18) Legislation authorizing grants to communities, under the Health Revenue Sharing Act, for an annual "Health Fair" for persons over 60 years old. Free medical checkups, including diagnostic screening, and appropriate referral, would be offered, and printed information relating to health education would be disseminated.

(F) MOBILE AND EMERGENCY HEALTH UNITS FOR THE ELDERLY

(19) Legislation authorizing *grants for geriatric mobile health units*, a doctor's office in a motor vehicle (generally a van), providing regular medical services for persons over 60. Services would include diagnosis, lab work, treatment, medication, follow-up, and referrals. The units would travel to various parts of the county on a regular basis and would provide advance notice of location.

(20) Legislation amending the Emergency Medical Services Act, Public Law 93–154, to target funds for the *research, establishment, and expansion of facilities and personnel in emergency centers*, both mobile and stationary, *specializing in the* emergency health needs of the elderly, and emphasizing coverage of areas in which large concentrations of persons over 60 reside. Twenty percent, or $14,000,000 of the $70,000,000 authorized for 1976 should be earmarked for this purpose.

IV. NURSING HOME AUDITING AND STANDARDS

(21) The subcommittee recommends to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce, *immediate legislative hearings on legislation including H.R. 8733, to require annual, unannounced, on-site Federal audits of medicare and medicaid* nursing homes. The subcommittee further recommends that, if faulty or questionable finances are found in any medicare or medicaid nursing home, HEW shall be authorized to audit the facility as many times during the year as necessary until the situation is corrected.

The subcommittee believes that such unannounced Federal audits should be begun immediately on at least a spot random basis, and recommends to *HEW* that the Department *immediately* develop a cost analysis of possible annual audits of all federally subsidized nursing homes for presentation to the Congress.

(22) An amendment to the Social Security Act providing that *no nursing home shall be permitted to require any patient to turn over social security benefits if the patient provides 30 days advance notice* that he intends to leave the nursing home. For those homes which receive Federal funds, this limitation shall be a requirement for the receipt of such funds.

APPENDIXES

APPENDIX I

MAJOR LEGISLATION IN HEALTH AND LONG-TERM CARE OF THE ELDERLY INTRODUCED IN THE 94TH CONGRESS

94TH CONGRESS
1ST SESSION

H. R. 1354

A BILL

To amend title XVIII of the Social Security Act to provide long-term care services as a part of the supplementary medical insurance program, to encourage the creation of community long-term care centers to assist in providing such services, and for other purposes.

By Mr. PEPPER

JANUARY 14, 1975

Referred to the Committees on Ways and Means and Interstate and and Foreign Commerce

94TH CONGRESS
1ST SESSION

H. R. 10827

A BILL

To amend the Community Mental Health Centers Act to require States which receive assistance under that Act to establish and maintain mental health advocacy services for persons involuntarily institutionalized

By Mr. FLORIO

NOVEMBER 19, 1975

Referred to the Committee on Interstate and Foreign Commerce

94TH CONGRESS
1ST SESSION

S. 2506

A BILL

To amend title XVIII of the Social Security Act to provide for the furnishing of outpatient rehabilitation services.

By Mr. RIBICOFF, Mr. BAYH, Mr. CANNON, Mr. HARTKE, Mr. HUMPHREY, Mr. INOUYE, Mr. JACKSON, Mr. JAVITS, Mr. MCGOVERN, Mr. MCINTYRE, Mr. MANSFIELD, Mr. MONDALE, Mr. PASTORE, Mr. PELL, Mr. PERCY, Mr. RANDOLPH, Mr. STAFFORD, and Mr. WEICKER

OCTOBER 9 (legislative day, SEPTEMBER 11), 1975

Read twice and referred to the Committee on Finance

94TH CONGRESS
1ST SESSION

H. R. 8733

A BILL

To amend title XIX of the Social Security Act to require the Secretary of Health, Education, and Welfare to conduct an annual audit of each hospital, nursing home, and other institutional facility participating in the medicaid program and each State or local agency distributing medicaid funds, and to amend title XVIII of such Act to require annual audits of providers of services under the medicare program.

By Mr. BEARD of Rhode Island, Mr. PEPPER, Mr. CONYERS, Mr. FISH, Mrs. CHISHOLM, Mr. GAYDOS, Mr. HARRINGTON, Mr. HEINZ, and Mr. MACDONALD of Massachusetts

JULY 18, 1975

Referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

94TH CONGRESS
1ST SESSION

H. R. 10422

A BILL

To amend part B of title XVIII of the Social Security Act to broaden the coverage of home health services under the supplementary medical insurance program and remove the 100-visit limitation presently applicable thereto, and to eliminate the requirement that an individual need skilled nursing care in order to qualify for such services, to amend part A of such title to liberalize the coverage of post-hospital home health services thereunder, to amend title XIX of such Act to require the inclusion of home health services in a State's medicaid program and to permit payments of housing costs under such a program for elderly persons who would otherwise require nursing home care, to require contributions by adult children toward their parents' nursing and home health care expenses under the medicaid program, to provide expanded Federal funding for congregate housing for the displaced and the elderly, and for other purposes.

By Mr. KOCH and Mr. MOAKLEY

OCTOBER 29, 1975

Referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

94TH CONGRESS
1ST SESSION

H. R. 1939

A BILL

To amend the Social Security Act to extend entitlement to health care benefits on the basis of age under the Federal medical insurance program (medicare) to all persons who are citizens or residents of the United States aged 65 or more; to add additional categories of benefits under the program (including health maintenance and preventive services, dental services, outpatient drugs, eyeglasses, hearing aids, and prosthetic devices) for all persons entitled (whether on the basis of age or disability) to the benefits of the program; to extend the duration of benefits under the program where now limited; to eliminate the premiums now required under the supplementary medical insurance benefits part of the medicare program and merge that part with the hospital insurance part; to eliminate all deductibles; to eliminate copayments for low-income persons under the program, and to provide, for others, copayments for certain services or items but only up to a variable income-related out-of-pocket expense limit (catastrophic expense limit); to provide for prospective review and approval of the rates of charges of hospitals and other institutions under the program, and for prospective establishment (on a negotiated basis when feasible) of fee schedules for physicians and other practitioners; to revise the coverage of the tax provisions for financing the medicare program and increase the Government contribution to the program; and for other purposes.

By Mr. MATSUNAGA

JANUARY 23, 1975

Referred to the Committee on Ways and Means

94TH CONGRESS
1ST SESSION

H. R. 4302

A BILL

To amend the Public Health Service Act to provide for the making of grants to assist in the establishment and initial operation of agencies and expanding the services available in existing agencies which will provide home health services, and to provide grants to public and private agencies to train professional and paraprofessional personnel to provide home health services.

By Mr. FRASER, Mr. STEELMAN, Mr. BALDUS, Mr. BADILLO, Mr. CARR, Mrs. COLLINS of Illinois, Mr. DOWNEY, Mr. EDWARDS of California, Mr. EILBERG, Mr. GILMAN, Mr. HARRINGTON, Mr. HAWKINS, Mr. HICKS, Ms. HOLTZMAN, Mr. MAGUIRE, Mr. MINETA, Mr. PRESSLER, Mr. RODINO, Mr. ROYBAL, Mr. STARK, Mr. STOKES, and Mr. VANDER VEEN

MARCH 5, 1975

Referred to the Committee on Interstate and Foreign Commerce

94TH CONGRESS
1ST SESSION

H. R. 6494

A BILL

To amend the Social Security Act to improve the survey and certification process, rate-setting and fiscal audit methods, and general regulation of nursing homes and intermediate care facilities under the medicaid program, and to provide for medical, psychological, and social assessment of long-term care patients under both the medicare and medicaid programs.

By Mr. KOCH and Mr. PEPPER

APRIL 29, 1975

Referred to the Committees on Ways and Means and Interstate and Foreign Commerce

94TH CONGRESS
1ST SESSION

S. 2470

A BILL

To amend the Social Security Act by adding thereto a new title XXI which will provide insurance against the costs of catastrophic illness, by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

By Mr. LONG, Mr. RIBICOFF, Mr. CANNON, Mr. HANSEN, Mr. HOLLINGS, Mr. INOUYE, Mr. MANSFIELD, Mr. MONTOYA, Mr. PERCY, Mr. HUGH SCOTT, Mr. WILLIAM L. SCOTT, Mr. TALMADGE, Mr. WEIKER, and Mr. YOUNG

OCTOBER 3 (legislative day, SEPTEMBER 11), 1975

Read twice and referred to the Committee on Finance

APPENDIX II

The following chart gives ratios of home help per 100,000 population in various countries as reported in May, 1973: [1]

RATIO OF HOME HELP PER 100,000 POPULATION IN SELECTED COUNTRIES, AS REPORTED IN MAY 1973

Name of country	Total population (in millions)	Number of home help [1]	Ratio per 100,000 population
Sweden	7,968	65,700	825
Norway	3,851	22,231	577
Netherlands	12,878	52,130	405
Great Britain	43,988	67,439	138
Finland	4,688	4,556	97
Belgium	9,531	4,018	42
Switzerland	6,150	2,060	33
Canada	21,377	5,000	23
West Germany	58,653	11,203	19
United States	203,166	30,000	15
France	49,756	7,144	14
Israel	2,879	273	9
Austria	7,373	355	5
Australia	12,296	30	0.2
Italy	53,708	50	0.1
Japan [2]	107,372	9,220	9

[1] International Federation on Aging (sic). "Home help" includes homemaker and supportive services provided by Federal, local, and private agencies.

The International Federation on Aging is an international organization comprised of organizations representing the elderly. The U.S. representatives to the Federation are the American Association of Retired Persons and the National Retired Teachers Association.

[2] Japanese figures supplied by Mr. Mikio Mori.

Source: International Council on Homehelp Services.

66-559—76——6

APPENDIX III

WITNESSES BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, MAY 5, 1975 THROUGH NOVEMBER 19, 1975

Informal Hearing—May 5, 1975—Washington, D.C.

Beaumont, Constance—Public Policy Director of AAHA
Brickfield, Cyril—Legal Counsel, American Association of Retired Persons
Boyle, Mr.—Legislative Director, IBW, Representing Harold Tate
Clarke, Elsie B.—Senior Program Planner, Division of Services for the Aged for the District of Columbia
Cruikshank, Nelson—National Council of Senior Citizens
Dickerson, Dr. Jack—Vice President, Kirschner Associates, Inc.
Griesel, Elma—Project Coordinator, Gray Panthers
Hess, Arthur—Deputy Commissioner of Social Security, Department of HEW
O'Brien, James—Department of Older and Retired Workers of the U.S. Steel Workers
Oriol, William—Staff Director, Senate Special Committee on Aging
Park, Judy—Legislative Assistant, NARFE
Quirk, Daniel—Director of Public Policy of the NCOA
Raviv, Sheila—National Council on Aging
Smedley, Larry—Associate Director, The Dept. of Social Security for the AFL/CIO
Sullivan, James—Special Assistant to the Executive Director, AARP
Tarr, Clarence—Vice President, NARFE
Weiner, Robert—Legislative Assistant to Hon. Edward Koch, M.C.

Informal Hearing—Discussion of Problems of the Aged—May 19, 1975—Washington, D.C.

Barker, Cozette—American Occupational Therapy Association
Batten, George—Director, West Essex Nursing Services, Inc., West Caldwell, NJ
Cornish, Larry—Deputy Director of Legal and Legislative Affairs, American Speech and Hearing Association
Dreisner, Richard—Attorney, American Academy of Physical Medicine & Rehabilitation; National Easter Seal Society
Fosdick, James—Kappa Systems, Inc.
Galkin, Dr. Jean D.—Director, Instructive Visiting Nurse Association
Goodsell, Vincent—Director, Division of Services and Programs for the Aging, Prince Georges County, Maryland
Leimer, Sandra—American Occupational Therapy Association
Solon, Dr. Jerry—Program Planning Officer, National Institute on Aging, NIH
Thompson, Ms. Frances—Nursing Home Coordinator for Prince Georges County Health Department
Verville, Richard—Attorney, American Academy of Physical Medicine & Rehabilitation; National Easter Seal Society
Viklund, Birger—Labor Attache, Royal Swedish Embassy, Washington, D.C.
Warner, Braxton—Field Services Coordinator, Nat. Assoc. of Social Workers: NCOA

Hearing—"Home Health Care Services-Alternatives to Institutionalization"—June 16, 1975—Washington, D.C.

Dunlop, Dr. Burton; and Dr. William Pollak—Research analysts, Urban Institute, Washington, DC
Horstman, Peter—National Senior Citizens Law Center, Los Angeles, CA
Koch, Hon. Edward I.—Rep. in Congress from the State of New York
Krill, Edward J.—V.P., American Bar Association Committee on the Legal Problems of the Aging

Marlin, David—National Council of Senior Citizens League of Research and Services to the Elderly, Washington, DC
Morris, Dr. Robert—Lecturer, author, and director, Levinson Gerontological Policy Institute, Brandeis University, Waltham, MA
Regan, John J.—Professor, University of Maryland School of Law, Baltimore, MD
Semmel, Herbert—Center for Law and Social Policy, Washington, DC
Trautman, Donald D.—Chairman, Legislative Committee, National Association of Home Health Agencies

Prepared statements submitted by:

Muskie, Hon. Edmund S.—U.S. Senator from the State of Maine
Schreiber, Hon. Martin J.—Lieutenant Governor of Wisconsin

Hearing—"Innovative Alternatives to Institutionalization"—July 8, 1975—Washington, D.C.

Adamovich, George D.—Administrator, Abbott Hospital Division, Minneapolis, MN
Kramer, Richard J.—Associate Administrator at Abbott-Northwestern Hospital, Minneapolis, MN
Krause, Daphne H.—Executive Director, Minneapolis Age & Opportunity Center, Inc.
Lampert, Judith B.—Assistant to the Executive Director, MAO
Mortenson, Alice—Past Chairman, Senior Citizens Committee, Junior League of Minneapolis
Varpness, James G.—Director of Field Services, MAO
Wolkowicz, Joseph H.—Attorney at law, Director of Legal Services, MAO
Yates, Helen, R. N.—Abbott-Northwestern Hospital, appearing on behalf of Dr. Farber
Prepared statement submitted by: Farber, Dr. Roger Evan, Community Medical Associates, board member (neurologist)

Hearing—"Auditing of Nursing Homes and Alternative to Institutionalization"—July 12, 1975—Providence, R.I.

Boday, Michael—CoChairman, Rhode Island Gray Panthers, and Chairman, Senior Citizens Busing
Brown, Joseph N.—Meals-On-Wheels, Inc.
Cohen, Earle F., M.D.—Practicing physician in Rhode Island
Curley, Elizabeth—Former President, Rhode Island Council of Senior Citizens
DiDomenico, Robert J.—Executive Director, Association of Home Health Agencies of Rhode Island, Inc.
Franklin, Peter—Special Assistant to the Secretary of Health, Education, and Welfare
Accompanied by:
Abdellah, Faye G., Dr., Assistant Surgeon General and Director of HEW Office of Nursing Home Affairs
Benz, Albert T. J., Assistant Director of State and local audits, HEW Audit Agency
Fallon, Neal, Regional Commissioner, SSA
Gavin, Vincent, Acting Regional Commissioner, SSA, Region I, Boston
McFague, Warren, Acting Regional Director, Region I, Boston
Parigian, Edward A., Regional Audit Director, Region I, Boston
Sullivan, Thomas, Director, Office of Long-Term Care Standards Enforcement, Region I, Boston
Kalina, Charles R. —Assistant Director, on behalf of Health Planning Council, Inc., Rhode Island
Mulvey, Dr. Mary C.—Cochairman, Governor's Task Force to Monitor Bimonthly Inspections of Nursing Homes; Director, Rhode Island Council of Senior Citizens; and Board Member of the National Council of Senior Citizens
Noel, Honorable Philip W.—Governor of the State of Rhode Island
Accompanied by:
Affleck, John J., Director, Department of Social and Rehabilitative Services, Rhode Island
Cannon, Dr. Joseph E., Director, Department of Health, Rhode Island
Slater, Eleanor F., Chief, Division of Aging, Rhode Island
Perregaux, Edmond A., Jr.—Executive Director, Homemaker-Home Health Aide Services of Rhode Island

Woulfe. Beverlie—Director, Scandinavian Home, and President for the Rhode Island Association of Facilities for the Aged
Appendix: Statements submitted by: Dupre, Kenneth, of the Catholic Inner City Center of Providence, R.I.; Kent County Memorial Hospital

Miami, Fla., Hearings—"Home Health Services for the Elderly"—August 5, 1975

Bostrom, Flora—Miami, Florida
Dalrymple, Dack—On behalf of the Honorable Paul Rogers, a Representative in Congress from the State of Florida
Dye, Lester—Citizen
Evans, Catherine—Case Supervisor
Friedman, Paul—On behalf of the Honorable Dante B. Fascell, a Representative in Congress from the State of Florida
Friedson, Max—Director, National Council of Senior Citizens
Goldberg, Harry—Miami, Florida
Gordon, Irma—North Miami Beach, Florida
Gordon, Honorable Jack D.—A State Senator from the State of Florida
Gowan, James—Miami, Florida
Hadi, Lucy—Director, Grants Management, State of Florida
Handelsman, Gene—Director, Aging, Health, Education, and Welfare, Washington, D.C.
Hayes, Thomas—On behalf of the Honorable Lawton Chiles, a United States Senator from the State of Florida
Jacks, Margaret—Director, Human Resources, Division on Aging, State of Florida
Lehnhard, Mary—On behalf of the Honorable Dan Rostenkowski, a Representative in Congress from the State of Illinois
Rubel, Sarah—Miami, Fla.
Sharp, Bob—Chairman, Commission on Aging, City of North Miami Beach, Regional Director of the National Council of Senior Citizens
Serchuk, Max—Regional Representative, National Council of Senior Citizens
Schwinghammer, Roger E.—Assistant Executive Director, Catholic Service Bureau, Inc.
Suarez, Luis L.—Director, Region II, Division of Family Service, Miami, Fla.
Weinstein, Leonard—Member of the City Council, Miami Beach, Florida

Miami, Fla. Hearings—"Home Health Services for the Elderly"—August 6, 1975

Adair, Vera—Associate Director, Visiting Nurse Association
Colton, Hazel—Chairperson, Advisory Board, Neighborhood Family Services
Demann, Betty—Vice Chairperson, Advisory Board, Neighborhood Family Services
Goldstein, Richard K.—Assistant Director, Department of Planning and Budgeting, Greater Miami Jewish Federation
LaMendola, Clark—Agency Operations Director, United Way
Mendel, Ed—Trade Union Counselor, New York City Central Labor Council, Member of New York City Taxidrivers Union, Local 3056
McGovern, Patricia—Associate Health Planner, Health Planning Council
Petry, Joanette—Supervisor, Visiting Nurse Association
Resnick, Thomas—Grants Management, United Way
Rutherford, James T.—President, Florida Association of Home Health Agencies
Schabacker, Paul—Associate Director, Health Planning Council
Schensul, Stephen L., Ph. D.—Director, Community Mental Health Program, Jackson Memorial Hospital
Smith, Kathleen—Director, Nursing Service, Florida Home Health Services
Trice, Jessie—Director, Visiting Nurse Association
Udell, Leda M.—Vice President of Health Services, Florida Home Health Services
Villaverde, Rafael—Executive Director, Little Havana Activity Center
Walker, Hattie—Geriatric Staff Member, Community Mental Health Program

Miami, Fla. Hearings—"Home Health Services for the Elderly"—August 7, 1975

Abdellah, Faye, Dr.—Assistant Surgeon General, Director, Office of Nursing Home Affairs, Public Health Services
Collines, Richard B.—Director, Family Health Center, Inc.
Dixon, Howard—Director, Legal Services of Greater Miami, Inc.
Dorsey, Joseph E., Dr.—

Franklin, Peter, The Honorable—Special Assistant to the Secretary, Health, Education, and Welfare
Godwin, Pauline, Dr.—Department of Health, Education, and Welfare
Goldbert, Bernard, B.—Director, Project Renew, Manpower Administration Agency, Metropolitan Dade County
Kroner, Donald K.—Administrator, Home Health Services
McManus, Sister Margaret—O.S.F., Administrator, St. Francis Hospital, Inc.
Merlo, Thomas J.—CPA, financial consultant to Home Health Agencies
Petry, Joanette—Visiting Nurse Association
Quint, Bruce, Ph. D.—Director, Senior Centers of Dade County, Inc.
Richman, Gerry—President-elect of Dade County Bar Association
Schieider, Janet—Director of Nursing, Home Health Services
Steinberg, Edward—Vice President, Aircraft and White Taxi Companies
Stirling, Mildred—Director, Social Work, Mercy Hospital
Thomas, Richard D.—Administrator, Coral Gables Hospital, Coral Gables, Fla.
Underwood, Walter—HMO Project Director, Community Health of South Dade, Inc.
Zack, Steve—President of Young Lawyers

Miami, Fla. Hearings—"Home Health Services for the Elderly"—August 8, 1975

Barbieri, Betty Lou—Special Programs Coordinator, Community Action Agency
Brown, William—Senior Administrative Assistant, Dade County Office of Management and Budget
Cainan, Mary—900 N.W. 145th Street, Miami, Fla. 33168
Compasori, Martha—Volunteer Services, City of Hialeah, Fla.
Dyer, Dr. John—Director, Dade County Office of Transportation Coordination
Ellis, Michele—Director of Paramedical Services, Florida Home Health Agencies
Fabacker, Father Ignasius—Gesu Church
Gibson, James—Director of Residential Homemaker Program
Gowan, James—8300 North Miami Avenue, Miami, Fla.
Hill, Hon. John—Representative in the Florida House of Representatives
Little, DuWayne—Federal Aid Coordinator, Dade County
Lotz, Aileen—Director, Department of Human Resources
Morrison, Isabelle—Robert King High Towers
O'Connell, Conleth S.—Director of Patient Services, North Shore Hospital
Perdue, Dr. Jean Jones—Director, Adult Placement Program, Division of Health Services of Office of Human Resources
Simmons, Lillian—4511 Northwest 170th Street, Opalocka, Fla.
Smith, John B.—Legal Counsel, Medical Personnel Pool
Willis, Frances—Director of Service Programs for the Elderly, Department of Human Resources
Willis, William—Director, IMPACT Program, Dade County, Fla.

Joint Senate-House Hearing—"Proprietary Home Health Care"—October 28, 1975—Washington, D.C.

Brown, Richard P.—Executive V.P., Unihealth Services Corp., New Orleans, LA
Byrne, John—President, National Association of Home Health Agencies
Dandstedt, Rudolph—Assistant to the President, National Council of Senior Citizens
Etzione, Amati—Center for Policy Research, New York, N.Y.
Hall, Hadley D.—Executive Director, San Francisco Home Health Services
Hawes, Gerald—Audit Manager, Office of the Auditor General, Sacramento, Calif.
Koch, Hon. Edward I.—Member of U.S. Congress
Martin, John—American Association of Retired Persons, Washington, DC
Moore, Florence—Executive Director, National Council for Homemaker-Health Aide Services
Pfau, Mary Ann—Coordinator of Ambulator and Home Care Nursing Services of the American Nurses Association, Kansas City, MO
Rawlinson, Helen—Director of Home Care, Blue Cross Assn. of Greater Philadelphia
Reese, Eva—Director, Visiting Nursing Service of New York
Semmel, Herb—Center for Law and Social Policy, Washington, DC
Smith, John—Legislative Counsel, Medical Personnel, Personnel Pool of America, Inc.
Starr, Janet—Executive Director, Coalition of Health Services, Syracuse, NY

Svahn, John—Acting Director, Social and Rehabilitation Services, Dept. of HEW
Tigar, Nancy—Asst. Director, Council for Home Health Services-Nat. League of Nursing
Trautman, Donald D.—Chairman, Legislative Committee, National Association of Home Health Agencies, Portland, OR
Warner, Dr. George—Special Assistant to the Commission of the New York State Health Department, Albany, N.Y.
Weikel, Keith—Director, Medical Services Administration, Dept. of HEW
Wilsman, Edward J.—President, Upjohn Homemakers Home & Health Care Services, Inc., Kalamazoo, MI

Hearing—"Comprehensive Home Health Care: Recommendations for Action"—November 19, 1975—Washington, D.C.

Blumenthal, Melvin—Special Program Advisor, Dept. of HEW
Cohen, Robert—Senior Staff Associate, National Association of Social Workers
Dandstedt, Rudolph—Assistant to the President, National Council of Senior Citizens
Dobrof, Rose—Associate Professor, School of Social Work, Hunter College, City Univ. of New York
Dubrow, Evelyn—Legislative Director, International Ladies Garment Workers Union
Erpenback, Dr. William J.—State Department of Public Intruction, Madison, Wisc.
Flemming, Dr. Arthur S.—U.S. Commissioner on Aging, Dept. of HEW
Franklin, Peter—Special Assistant to the Secretary, Dept. of HEW
Lane, Lawrence F.—Legislative Representative, American Association of Retired Persons
McDonough, Patrick J.—Assistant Executive Director, American Personnel and Guidance Association
Sopper, Dale—Acting Deputy Assistant, Legislation and Health, Dept. of HEW
Trautman, Donald—Chairman, Legislative Committee, National Association of Home Health Agencies
Willging, Dr. Paul R.—Deputy Commissioner, Medical Services Administration, Department of Health, Education, and Welfare

ADDITIONAL VIEWS

ADDITIONAL VIEWS OF WM. J. RANDALL, CHAIRMAN

First let me make it clear that the reason these views are submitted is because of the importance and far-reaching effects of the content of the report entitled, "New Perspectives in Health Care for Older Americans."

I have asked that these comments to accompany the report be described as additional views. It would be misleading to say they are dissenting views. It would be unwise to describe these comments as minority views. Moreover, to call the following separate views would not be true because I am not separating myself from all of the report. Rather, I embrace much, indeed most, of its contents. It would be inaccurate to call this effort supplemental views because I have not had the time to do the research to supplement some of the conclusions and recommendations.

I have had an opportunity to read and study the subcommittee report, and after doing so I offer the following additional views.

In between and found amidst a total of 22 separate recommendations there are two principal or paramount goals or objectives which stand out as the dominant thrusts of the report as follows:

1. A reduction in proliferation and fragmentation of programs for the aging as culminated in the proposal to create a new Committee on Health in the House; and

2. The recommendation for alternative care or "a right to choose" to avoid institutionalization of our aging Americans.

Considered from its four corners, the report represents the diligent and dedicated effort of the gentleman from Florida, Mr. Pepper, and the members of his subcommittee to respond to the challenge of one of the most important problems of all of our older Americans—health and long-term care. Only income protection would have priority over long-term health care and that only because, in the last analysis, it is income maintenance that makes possible any creature comforts, including health.

In commenting upon the second of the two dominant targets of the report, that which the subcommittee describes as "inappropriate institutionalization," let me say as enthusiastically as I can express it that my hat is off in salute to the subcommittee for its proposal to extend and expand home health benefits under existing programs.

The subcommittee is to be congratulated upon its proposal for innovative alternatives to institutionalization. About the only complaint that I would have is that this is not really a separate subject at all but could well have been included in Chapter II. But that is a matter of editorial choice.

Such proposed innovations as outpatient clinics specializing in geriatrics, multi-purpose senior centers with both health and nutritional

facilities, elderly day care centers, and mobile health units are all quite meritorious.

The subcommittee is, moreover, to be commended for its idealistic (although thought by some to be an unattainable) goal which is expressed in the proposal to establish community long-term care centers, to avoid institutionalization. This proposal may very well become, in the future, the needed linkage to bring together the current fragmented health delivery system for older Americans.

The proposal to create a new committee on health in the House is one of the most important proposals in the report. In general I concur with the proposal, conditioned upon a few reservations and qualifications which I shall now recite.

It is noteworthy that the old and now dissolved Select Committee on Committees, in a Staff Report issued in 1973 mentioned the need for a separate committee on health in the House. But to me it was significant that the proposal was never contained in the final draft which made recommendations to the House. I suspect the likely reason for the omission is that the Select Committee on Committees recognized the difficulty to obtain favorable approval of such a proposal in the House.

It would be an over-statement to say that this proposal will be greeted with enthusiasm among the committees which now hold this fragmented jurisdiction.

It would be an under-statement to say that we can look forward to any generous applause from the respective committees. Certainly there will be no clapping of hands by the members of the Ways and Means Committee, the Interstate and Foreign Commerce Committee, or the Committee on Education and Labor. But the absence of enthusiasm or acceptance by those whose jurisdiction would be affected does not mean that the proposal is not sound. Perhaps some day such a committee will come into existence.

About the only complaint that I could register is that the recommendation was not based upon more extensive hearings. For example, I think the members of the standing committees affected should have been given the opportunity to recite their reasons for the formation of such a new committee in open hearing, or to voice their objections, if any, to the formation of the new committee. I also have concluded there should have been a larger number of outside witnesses heard and cross-examined on the proposal rather than the few who were heard prior to making the recommendation.

A point to be made as a compliment rather than a criticism is the fact that this report is an almost totally or completely revised version of a report which was submitted to the full committee on December 11, 1975. I think the revised report could be characterized as a condensation of the original draft of the subcommittee in the sense that the old report contained 62 recommendations while the present report, covering the same subject matter, contains 22 separate recommendations.

Now, if I am to be straightforward, I must cite a few specific complaints which I am left with no choice but to voice and no alternative to avoid unless I let the record stand as being in total and complete agreement with each and every one of its recommendations, as follows:

1. While the proposal for a clearinghouse in HEW for home health services is quite meritorious, it is difficult to understand why such a clearinghouse should be limited to home health services. Why should we fail to go beyond such a limited purpose, and instead provide that the same clearinghouse serve as a source of information and guidance on all health programs and benefits for the aging within the Department of HEW?

2. I read with considerable interest the proposal to fund certain counseling services out of medicaid and medicare funds. On its surface this proposal seems quite acceptable, but if we look just a little beneath the surface we have to consider that such a drain on medicare and medicaid funds could become so excessive as to render the two existing funds insufficient to carry this additional burden. Moreover, the proposal for counseling would be conditionally acceptable as long as it were limited to the elderly themselves who may be sick or disabled. Yet when the recommendation goes beyond that and calls for the counseling of all of the families of the elderly who are sick or disabled, then such a recommendation becomes so broad that it could very well include all of the families in the United States and thereby become a financial burden upon medicare and medicaid funds which would be intolerable.

3. It is my view that those recommendations which contain proposals for demonstration or pilot projects and which call for increased expenditures should have been costed out by some comparative showing or presentation of probable costs in relation to potential benefits.

4. The proposal that there be a funding of programs to encourage older persons to make periodic visits to other elderly persons is, in my judgment, not a proper subject for legislation. In fact, the Lou Harris Survey has shown that no urging is needed to encourage older persons to visit as long as they are physically able and as long as they have any means of transportation. They enjoy visiting those of their same age.

In the nature of a compliment rather than a criticism, I note that there is a chapter of the report entitled "Important Areas for Future Study in Long-Term Care." It is my hope that the subcommittee might benefit from some experience gained by this report as it goes about the preparation of its second report. One thought which I advance, as an additional view, is that there are enough good proposals in this report to provide the basic material for half a dozen reports rather than including so many matters of such great importance in one single report. I would hope that in the future in the areas considered in Chapter V such reports will be broken down into separate subjects rather than have several important subjects all combined in one report.

In the final analysis the report is an example of pushing ahead the work of better long-term health care. One of our wiser men, whose name I cannot momentarily recall and therefore cannot attribute to him credit for his idea, expressed the thought that the only way to avoid criticism is to do nothing. This report is an example of doing something constructive rather than failing in its duty to pursue its work and present a report on long-term health care. On that score the subcommittee rates A-plus.

The subcommittee has worked hard. There is no question about that fact. It has moved forward the work of the new Select Committee on Aging and in particular the mandate cast upon its shoulders by the House in October 1974, when the committee was created to conduct a continuing and comprehensive study of the problems of older Americans.

As chairman of the full committee of the new House Select Committee on Aging, I am grateful and appreciative for the hard work of all of the members of subcommittee No. 2.

Wm. J. Randall, *Chairman.*

ADDITIONAL VIEWS OF REPRESENTATIVE BOB WILSON

The recommendations of the subcommittee are generally worthy of serious consideration.

I am, however, concerned about the proposed changes in medicare and medicaid. It would seem to me that the proposed additional services will impose a substantial economic burden.

I am not convinced that sufficient attention has been given to the actuarial implications of these proposed additional services. The financial integrity of the Social Security Trust Funds might well be jeopardized by some of the proposed additional services.

BOB WILSON.

ADDITIONAL VIEWS OF REPRESENTATIVE WILLIAM F. WALSH

While the report of the Subcommittee on Health and Long-Term Care does, in fact, offer some excellent and far-reaching recommendations for an end to the proliferation and fragmentation of laws dealing with elderly health and for alternatives to institutionalization for senior citizens, there exist several areas in which those recommendations are ill-conceived.

NEW COMMITTEE ON HEALTH IN THE HOUSE OF REPRESENTATIVES

The creation of a new committee on health in the House of Representatives would not effectively lessen the confusion in dealing with health issues of the elderly; rather, such a restructuring attempt would serve only to intensify existing jurisdictional disputes. Additionally, a new House committee on health would necessarily address itself to health matters pertaining to the entire populace, rather than limiting jurisdiction to the area of elderly health. A more realistic approach would make this committee a permanent one. This committee is becoming experienced in the problems of the aged; additionally, the ever-increasing proportion of our elderly population suggests this is an issue which must be codified and dealt with as a whole. The elderly now make up about 10 percent of the population of the United States or 21 million people. This is expected to climb to about 29 million in the year 2000.

PROLIFERATION OF DEMONSTRATION PROJECTS

While the subcommittee's report calls for a number of alternatives to institutionalization, it calls for demonstration projects to test the feasibility for such suggestions with wild abandon, often when prototypes already exist. Such a policy would effect the expenditure of unnecessary funds which would ultimately serve to benefit those engaged in the creation and administration of the projects rather than the elderly themselves. Additionally, the time involved in attempting to demonstrate a fact which in many instances has already been proven means there will be a substantial delay in providing the recommended alternative services to the aging population. Examples from the report clearly serve to illustrate this contention:

1. The subcommittee's recommendation No. 9 calls for a series of demonstration and pilot projects to determine the effectiveness of various home health and supportive services. Testimony before the subcommittee on June 16, 1975, in fact, cites a number of studies in this area which have shown that home health and supportive services are desirable and additionally, that they are cost effective. Demonstration and pilot projects of this nature would, therefore, be completely unnecessary.

2. That part of the subcommittee's recommendation #14 calling for legislation commemorating the Minneapolis Age and Opportunity Center as an excellent prototype for other outpatient senior centers, and appropriating $500,000 to the Center for a demonstration project of collating relevant information on its method of operation and disseminating these materials to State Health Commissioners, State Commissioners of Aging, and other interested parties across the country is, on its face, unnecessary and, therefore, cost exhorbitant. The Minneapolis Center is available for the inspection of all interested parties. Those State officials who are interested in the methods employed need only contact the appropriate officials at this or the many other centers of this type across the country for any information they might desire.

Other recommendations for demonstration projects are either not well enough conceived or provide a cost figure which seems to be purely arbitrary, as no documentation has been provided by the subcommittee. For instance,

1. The report calls for pilot programs under the Older Americans Act to provide home services to the terminally ill of low income so that patients can die in the dignity of their own homes, rather than in institutions. Such a recommendation is, of course, socially and humanely desirable; yet, the recommendation fails to provide any cost estimate.

2. The report calls for legislation authorizing $10,000,000 for demonstration projects increasing the outreach capabilities of existing nonprofit outpatient clinics specializing in the care of the elderly by the development of related miniclinics located in nearby cities and counties. In addition to being duplicative in nature, no documentation has been furnished to justify the cost estimate.

3. The report recommends that a minimum of $150 million in additional funding be authorized for the modernization, construction, and conversion of medical facilities for outpatient clinics specializing in care of the elderly: again, however, no documentation has been provided to justify the $150 million figure.

INCLUSION OF FREE-STANDING CLINICS UNDER MEDICAID

The subcommittee report recommends that the states be required to include free-standing clinic services under medicaid. We must bear in mind that while the Federal Government does provide some funding for the medicaid program, it is administered by the States as stipulated in the enacting legislation. Therefore, requiring that free-standing clinic services be required under medicaid is an unwarranted Federal intrusion on State jurisdiction.

Each of these points, as well as the other recommendations of the subcommittee, should be considered carefully with an effort to making the lives of the aging as pleasurable as possible at the earliest possible date in the most efficient cost-effective manner available.

WILLIAM F. WALSH.

SUPPLEMENTAL VIEWS

SUPPLEMENTAL VIEWS OF REPRESENTATIVES MICHAEL T. BLOUIN, THOMAS J. DOWNEY, AND WILLIAM J. HUGHES

Our views are written not in opposition to this report nor do we take issue with any particular part of the report. Rather we would like to use this opportunity afforded us by the committee to both commend Congressman Pepper and his staff, along with the other members of the Subcommittee on Health and Long-Term Care, for the excellent job they did in preparing this report. We would also urge the full committee to take whatever action is necessary to present the views of this report to the full Congress and to those committees having jurisdiction over this legislative area.

The facts as presented in support of the recommendations presented in this report, represent months of hearings and we know the subcommittee members spent much of their valuable time going over the facts as presented to them by the wide assortment of witnesses who were asked to testify before them.

It seems to us that this report provides credence to what we have considered to be a major problem regarding elderly health care, that problem being that current health care programs for the elderly are so fragmented at all levels of government that it is difficult to not only bring continuity to elderly health care, but it is just as difficult to fully understand just what health care services are available to serve the elderly.

In addition to the problem of proliferation and fragmentation of health programs for the elderly, the report also substantiates the need for redirection in elderly health care from one of institutionalization to that of home-health care. Although HEW has maintained that home-health care should be a goal of government health care assistance programs, the fact remains that it has not been carried out. If anything, current policy as interpreted in both Federal statute and HEW regulations, has almost made permanent the concept of institutionalized health care. A new focus by the Congress on this issue is badly needed.

It is our feeling that the full committee should study the recommendations of this report thoroughly and discuss them as a committee, perhaps identifying what we as a committee feel are the major priorities of this report and then to formulate the mechanism by which to best implement these recommendations into law.

Our major concern in presenting this supplemental report to the committee, is to echo the concerns expressed by our colleague from California, Mr. Roybal, that being that this report should be one that will help bring about substantive change in elderly health care and that it will be used as a foundation by the committee to enact the

legislation needed to make adequate health care for the elderly a reality in this country. It should not be considered by the committee members as just another report to be shelved among the many reports received each Congress.

Michael T. Blouin.
Thomas J. Downey.
William J. Hughes.

SUPPLEMENTAL VIEWS OF REPRESENTATIVE DON BONKER

I would like to commend the Chairman, Rep. Claude Pepper, and the Subcommittee on Health and Long-Term Care for focusing attention on the need to provide older citizens with alternatives to institutionalized care. I am also pleased to note the general support for the subcommittee's recommendations on home health care from the National Cancer Foundation, the National Council of Senior Citizens, and the National Association of Social Workers. The subcommittee, I believe, has been extremely helpful in pointing out the institutional bias of our existing legislative programs.

While I am impressed by the sense of concern and commitment which permeates the report, I do have reservations about some of its recommendations. Since many of the recommendations require further study, I agree with the statement in the report on page 3:

> The subcommittee intends to conduct further research into the issues raised and to strengthen and revise the recommendations as changing national health situations and new documentation may direct. The subcommittee will continue to work toward implementation of both the current and new recommendations as justified by the facts.

We should know more about the problems of enforcement of existing regulations and standards; dissemination of information; providing an adequate accounting system; coordinating existing programs; and restructuring, before we can improve the delivery of services for the elderly. I hope that eventually the committee will be in a position to make suggestions to Congress that would, for example, facilitate the retraining of retired firemen as nursing home inspectors wherever a shortage existed, and retraining of retired auditors, to help when there is a backlog of claims to be verified.

The committee should look at the entire question of enforcement of all the regulations pertaining to the elderly, which might incidentally be a good time to ferret out the conflicting regulations. Until this is done, I am hesitant to endorse suggestions to increase HEW's regulatory responsibilities, especially ones which are the equivalent of self-regulation, since we are dissatisfied with HEW's performance as regulators.

As far as improving outreach methods, I would like to know how many people would be served by existing programs if they were aware of them, and how many people have problems which have not been touched by legislative programs. This analysis would enable us to provide the most effective methods of outreach. The idea of a clearinghouse which provides information, gives assistance with grantsmanship, helps States with coordination of plans and programs, and coordinates all Federal programs for the aging is very appealing. I would prefer that such a clearinghouse be concerned not only with health

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but with all the programs for the elderly. Also, I would like to see such a clearinghouse employ senior citizens, especially on a part-time basis. While I am reluctant to provide HEW with more duties, we might consider strengthening the clearinghouse in the office of the aging and making our intentions very clear. The clearinghouse should naturally utilize a computer system if needed, but I think it should be independent of existing systems and provide information about all programs for the elderly.

And finally, it is obvious that a thorough reorganization of HEW is needed, but it would be precipitous to take such measures without the benefit of further study.

Again, Chairman Pepper and his colleagues on the subcommittee deserve a great deal of credit for an extraordinary amount of work in such a short time. This report represents a significant contribution to the further understanding of elderly health care problems, and the attached recommendations are a good starting point for ameliorating the many difficulties faced by senior citizens today.

DON BONKER.

SUPPLEMENTAL VIEWS OF REPRESENTATIVES H. JOHN HEINZ III, WILLIAM S. COHEN, WILLIAM F. WALSH, CHARLES E. GRASSLEY, JOHN PAUL HAMMERSCHMIDT, AND GILBERT GUDE

SUMMARY OF VIEWS

This report focuses on what is missing in our laws and our regulations directed at the elderly—a sense of the person. It moves away, at last, from an outdated concept of institutionalization as the only answer to the problems of the elderly and addresses their urgent and pervasive health needs. Institutionalization was a solution that separated the elderly from their community and the society from the many contributions they have to offer.

We join with our colleagues in calling for alternatives to institutional care. We would go beyond this to advocate a program for developing more humane alternatives for the elderly within institutions.

We believe that local and state as well as Federal initiatives are urgently needed in ending the emphasis on institutionalization and focusing on improving the health of the elderly. Proliferation and fragmentation of services exist at all levels of government.

We will work for the development of policy and the passage of legislation that would provide not only home care programs, but also programs of congregate housing with health and social services.

We advocate a program for health care reform for the elderly which includes the following:

(1) Changes in the payment system for long term care. Instead of per-capita reimbursement, we favor compensation on the basis of disability similar to the veterans disability payment system. This will leave the elderly free to choose the type of care they need.

(2) A system of community information and personal services that will give older persons the assistance they need to make an informal choice.

(3) A new set of legislative and regulatory initiatives at all levels of government that makes care institutions and providers of health services directly accountable to the person who is receiving care.

(4) Close scrutiny of the use of public funds through the development of provisions such as community advisory panels composed of consumers, providers, and the general public.

(5) Adequate Federal support for State and local governmental regulatory activities, to ensure adequate review of relevant programs.

(6) Development of state responsibility for establishing public receivership for the administration of provider groups who do not keep the public trust until competent administration and quality of care is restored.

(7) Employment and retraining of older Americans for the purpose of administering, monitoring, and reviewing the delivery of their own and others health and social services.

Many of the recommendations of the subcommittee are worthy of adoption. We offer supplemental views only on those which we feel might lead to unfavorable consequences for care of the elderly if they were adopted. We agree with our colleagues that the establishment of a spectrum of coordinated health and social services for the elderly should be among the highest priorities of Congress as it considers new legislation. To this end we pledge our full cooperation and effort.

GENERAL COMMENTS

We are in strong agreement with our colleagues who in this report call for recognition by Congress and the tax payers of America that our elderly are entitled to support for a broader spectrum of health care services. Several of the recommendations proposed have the potential to improve the delivery of health services in the community. The general thrust of the report set forth in the introduction, and the follow-through advocated by the subcommittee in Chapter 5—Important Areas for Further Study in Long-Term Care—are vital contributions to a new Congressional and public dialogue on the health care needs of the elderly. Many of the general goals outlined in Chapters 2, 3, and 4 concerning the development of alternatives to institutionalization, extending home health benefits, and improving quality control, enforcement procedures and standards in long term care facilities, are worthy ones which we wholeheartedly endorse.

We are concerned, however, that the individual recommendations are not in every case sufficiently supported by the narrative which precedes it.[1] Fuller evaluation than this report is able to provide is needed to examine the impact of its recommendations on existing health programs for the elderly and on the health financing, administration, and delivery. In particular, more work could be done on the recommendations which call for specific or substantial additional funding or transfer of funds. We believe these should be reexamined as soon as the subcommittee receives studies and expert testimony.

We believe that it is important for the subcommittee to share its initial findings and goals with both the legislative committee and the public at large. It is unfortunate but probably unavoidable that the approach taken by the report—that of proposing unprioritized multiple recommendations—does not lend itself as much as we would like either to immediate legislative enactment of needed, remedial measures or to the development of new approaches.

We hope that this report will be effective—both as a vital communication document to other committees and as a catalyst for effective legislative response. It is our feeling that if the report retained its broad scope but made fewer recommendations, analyzed those that it made more thoroughly, and clearly placed remedial actions and long term solutions in some priorities, perhaps the standing legislative committees of the House would be able to move more quickly in the areas of greatest need.

An example of an initiative that we would like to see fully developed is home health care. The report asserts that home health care "would

[1] See comments on individual recommendations below.

reduce costs as much as $700,000,000 nationwide (subcommittee report p. x). We fear that this statement is insufficiently supported by the analysis. It is based in large part on rough estimates of the number of elderly persons who are currently inappropriately institutionalized and some selected case studies of potential hospital savings under programs of home care, such as those of the Minneapolis Age and Opportunity Center. But nowhere in the report is a specific definition of home care given. Nor is empirical evidence offered which identifies the levels of functional impairments of older persons or those for which home health care, homemaker and supportive services, foster care, or congregate housing are appropriate. Accurate data on the proportion of presently institutionalized persons who could be better served if less expensive, more humane settings is missing. Data on the proportion of the elderly population who are inappropriately placed in noninstitutional settings is lacking in the report.

In fact it may well be that the number of elderly persons who have need for home health, personal, and domiciliary care are underestimated in the report. Analysis of studies conducted by Hill and his associates in Rochester,[2] Sproat of the Levinson Institute at Brandeis, Massachusetts,[3] Dunlop,[4] and others indicate that there may be over 6 million elderly persons who require or could benefit from such services.

We agree completely with our colleagues that expansion of such forms of care are urgently needed. We are less certain than they that present or future costs of long term care can be reduced by providing a broad spectrum of unlimited home health and home care services as the primary alternative to institutionalization. To put forth specific figures of how much money can be saved is misleading. There is little doubt that some institutionalized persons who do not have major functional impairment can be better served by providing alternative care. However, there is also clearly a potential for home health services if defined too broadly or for patients of high disability, to be more expensive alternatives to nursing home care for elderly persons.[5] [6] [7]

In considering the cost of providing care to the elderly Congress must look not only at cost to the government, or number of institutional bed days saved, but also to "the social cost of providing care to a given quality to an individual with a specified level of functional competence and family status".[7] This cost presently varies by region and locale in the U.S. as a function of different prices and different standards of care. The report fails to address this aspect sufficiently.

The subcommittee must confront the prospect that the home health recommendations it has made in the report may not only lead to some

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[2] Hill, J. C., et al, *Health Care of The Aged Study,* Rochester, New York, University of Rochester, School of Medicine and Dentistry, 1968.

[3] Sprout, B. J., *Three Approaches to Estimating Need for Personal Care Services,* Waltham, Mass., Levinson Gerontological Policy Institute, Brandeis University, June 1972.

[4] Dunlop, B. D., Long-Term Care: *Need Versus Utilization,* Urban Institute Working Paper 0975–05, Washington, D.C., Rev. Feb. 7, 1975.

[5] Marie Callander and July Lavor, *Home Health Care Development, Problems and Potential Disability Long Term Care,* DHEW, Office of The Assistant Secretary for Planning and Evaluation, April 1975.

[6] William Pollak, *Utilization of Alternative Care Settings by The Elderly: Normative Estimates and Current Patterns,* Urban Institute Working Paper 963–12, Washington, D.C., March 13, 1973.

[7] William Pollak, *Costs of Alternative Care Settings for The Elderly,* Urban Institute Working Paper 468–11, Washington, D.C., March 12, 1973.

long term cost-effectiveness for some proportion of the elderly population, but also may lead to significant short term increases in cost as people who marginally need such services take advantage of their availability. Home health care is better viewed, but as a basic part of the continuum of health care needs. This continuum of care must include better and more humane care alternatives within institutions as well as alternatives to institutions.

We are in substantial agreement with and have chosen not to comment on the recommendations numbered 1, 5, 7, 10, 11, 12, 15, 16, 17, 18, 19, 20, 21, and 22. Most of the above recommendations would benefit from more careful analysis, in line with our general comments above, but they are clearly steps in the right direction. The recommendations below, numbered and ordered to conform with their numbering in the report, are those for which we wish to submit supplemental views. It is our hope that these views will lead to a fuller understanding of the complex problems facing both our elderly and our society.

Recommendation No. 2: Creation of a new House Health Committee

The findings of overlapping Congressional jurisdiction in the health area cited in the report are necessarily true for any broad area of public concern. In a nation of over 210,000,000 people such issues are complex and often require the attention of policy makers with diverse legislative charges. Consideration of bills through the joint or sequential referral powers of the Speaker of the House are quite appropriate in matters which affect both health and the general economy, as do all proposals for national health reform.

Health as a separate subject matter is one of the least fragmented areas in the Congress. There are only two subcommittees that share legislative jurisdiction in the House of Representatives with health as the specific concern. Both subcommittees, the Health Subcommittee of Interstate and Foreign Commerce and the Health Subcommittee of Ways and Means. have considerable expertise in health care issues as well as general backgrounds that equip them to deal with health delivery and health financing issues. We know of no reason why such committees cannot work effectively together.

The creation of a new health committee also raises the basic question of whether we should grant the power of taxation to a committee besides the House Ways and Means Committee. It appears likely that any comprehensive national health program will involve some form of direct taxation and funding through the general revenue. We believe that a reasonable case can be made for keeping the powers of taxation under the jurisdiction of one committee. To split these powers, and give them to additional committees may lead to additional problems in achieving equitable income security on the one hand and health security on the other.

The problem as we see it does not concern so much the number of committees or subcommittees that have jurisdiction over matters which affect the health of the elderly. Rather, it is getting the committees which have jurisdiction over the health of the elderly, to start paying attention to the health needs of the elderly, that needs our attention. Furthermore, to specify the exact mix of Members for the new Health Subcommittee without careful study which justifies this particular organizational structure is premature at best.

The assertion that the creation of one committee is "the only way to guarantee future rational health planning" (see p. 47) is unproven. The groundwork for such planning has already taken place, having originated in the Health Subcommittee of the House Commerce Committee (Public Law 93–641).

Hearings on the relationship of long term care to national health insurance have been scheduled by the Health Subcommittee of Interstate and Foreign Commerce with the help from this subcommittee. The chairman of the subcommittee has asked a Member of the Ways and Means Committee and a Member of the Select Finance Committee (both of whom have introduced bill referred to in Recommendation No. 1) to testify. Both have accepted. We believe that that type of coordinated action will do far more to insure congressional responsiveness to the problems of the elderly than will setting up a new committee, which itself may take months or years to establish and whose credibility—with other committees may take months longer to cement—as all members of our new committee will surely admit.

The creation of a new health subcommittee in the name of nonproliferation, delay, and fragmentation in our view would lead to additional delay and fragmentation.

Recommendation No. 3: Creation of a comprehensive home health clearinghouse

We believe that locally based community wide clearinghouses are needed in the first instance to provide the elderly with increased information on home health and other services available to them. Placing heavy emphasis on a nationwide computer-based information network as a means of achieving individual access to information is a costly and circuitous route to take.

A computer will not necessarily solve the problem of giving the elderly a means to understand what benefits are available to them, and how they may best receive them. First priority should go to the strengthening and coordination of local services (including information services on home health). Part of this effort will involve giving the elderly individual assistance in their own community so that their needs may be determined and their ability to choose, maximized.

Recommendation No. 4: HEW reorganization under an Assistant Secretary for Elderly-Health of all health and health-social matters for persons over 60

Long-term care is presently organized and administered along statutory rather than functional lines. It is this fact that would make it difficult for an Assistant Secretary for Elderly Health to practically achieve the leadership, line authority, and responsibility for coordination of home health and other "alternative" programs which the report finds lacking in the Office of Nursing Home Affairs. A principal block to a more rational or coordinated long term care policy within HEW is the fact that medicaid as a Federal-State revenue sharing program has different and incompatible arrangements for program management, delivery, payment, and quality control, from that of medicare, or the Older Americans Act. Even other structurally similar Federal-State revenue sharing programs like Title XX (Public Law 93–647)

the Social Security Act have little potential for integration with title XIX or Federally managed categorical programs for the elderly.

Until such time as medicaid which presently has most of the long-term care dollars and services is Federalized or otherwise radically changed, or, alternatively, the other programs are structurally revised to give the states the same control over delivery of services and regulation as exists in title XIX, it will be difficult to significantly alter the situation.

Programs such as legislation under Recommendation No. 1 of this report may have significant potential to change the situation by virtue of the fact that they contain provisions that will coordinate all long-term care services under one system of administration and regulatory control.

The recent experience of HUD, which has an Assistant Secretary for the Elderly, also should give pause as we recommend the creation of an additional high office within HEW for the elderly, an Assistant Secretary for the Elderly, as the best way to solve the problem. A recent briefing with representatives of the Assistant Secretary for Elderly Housing, before the Housing and Consumer Affairs Subcommittee indicated that having a high official advocate for the elderly within HUD has not produced the kind of implementation activities that will lead to material gains in the provisions of additional community and home services for them. There has not been significantly greater utilization of existing programs or laws to increase the quantity and quality of housing for the elderly since the office was created. In part this is because the responsibilities of the Assistant Secretary for Elderly Housing include no line responsibility of administration authority; the Secretary's functions are "to review policies, * * * participate in planning for inspection and evaluation of HUD assisted housing * * * and represent HUD in meeting with other * * * organizations." [8]

It is obvious that some form of functional reorganization within HEW is necessary. What form this might take is not yet clear. We have reason to believe on the basis of past experience that the creation of an Assistant Secretary for Elderly Health with actual line authority over all health and health-social matters as the report suggests would be impractical and might further split-off and isolate the needs of the elderly from the general health resources available within HEW. The Commissioner on Aging already offers older Americans a high ranking official advocate within HEW. The creation of an additional bureaucracy within HEW has the potential to create as many problems as it solves.

Recommendation No. 6: Home health benefits under medicare and medicaid

We strongly favor the general intent of the recommendations, but take issue with some of the sub-recommendations under No. 6:

The first recommendation for legislation under No. 6—the addition of a full range of homemaker and other correlative services to medicare's current coverage of doctor and nurse visits and full provision of medical supplies and appliances are not accompanied by estimates of cost of benefits, eligible population, or estimated utilization of those

[8] Annual Report to Senate Special Committee on Aging—1974 Highlights.

eligible. An informal study done of homemaker services using nationwide figures for title XIX cash assistance recipients as the base population yields the following results: [9]

Under medicare part B approximately 21.3 million persons would be eligible for homemaker and other correlative services. Assume that 40 percent of the elderly population utilize these services and that costs for a "full" spectrum of services average about $605 per individual. As an alternative, assume that 40 percent of the eligible population who utilize these services will on the average only use about one half of the total services—in cost—then, the costs of including such services under medicare would range from a low of $2.5 billion to a high of $5.1 billion a year.

The above rough cost projection does not take into account the provision of medical supplies, hearing aids, dental care, podiatry, and sight aids, for which no utilization and cost data were readily available, and what burden either medicare or medicaid as presently constituted could carry.

If we add to these a full home health benefit with estimates of the eligible population at 25 million people under part B of medicare, and an estimated utilization ranging from a low of 6.1 percent (derived from the Pennsylvania State and New Hampshire figures on utilization) [10] to a high of 16.9 percent using a general definition of "unable to remain at home without such support"—as estimated from national studies—the cost of home health under the medicare arrangement ranges from $345 million to $1 billion. Of course these estimates are gross and the assumptions upon which these figures were generated are tentative at best. However, it does point to the need to consider the full impact of such a program on our existing Medicare system.

Arthur E. Hess, Deputy Commissioner of the Social Security Administration speaking at a gerontology conference at the University of Michigan on August 14, 1975, has said,

> for reasons of cost and because I do not think medicare should really get into long term care, I propose * * * to continue the present skilled nursing care provision * * * For the long run, we ought to put more money into home care * * * A revised program which would do away with distinctions between Part A and Part B could provide 200 home health visits per calendar year without any prior hospital stay requirement subject to the present medicare criteria. Then, I would rely on emerging experience from a number of experiments which are now being conducted to determine the appropriateness of the situation in which the services of the home health aide or other relaxation of the medicare criteria for organized home health services are shown to make a useful difference in the individual and his family.—Arthur E. Hess: "Next Steps in Medicare, Speech at the University of Michigan, August 14, 1975, Conference on Gerontology, pp. 24 and 25.

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[9] Source: Social and Rehabilitation Service (Medical Service Administration), M.C.S.S. A–2 Reports, July 1972, June 1973.

[10] Using Pennsylvania and New Hampshire averaged estimates of the cost of home health services—which have the most complete home health benefits under medicaid.

Thus, while we are in agreement (as is the administration and many other sources) that there is a need to increase both the home health and homemaker services under medicare and medicaid, the call for immediate implementation of a full range of benefits is premature. We must first know the consequences both in terms of dollars and in terms of direct health benefits for the individual per dollar spent before embarking on this full scale program.[11]

Similarly we believe that the provision under No. 6 which permits the state Medicaid programs to cover payment of rent, mortgage, repairs and property taxes for the elderly or disabled person, may lead to serious imbalance in the reimbursement system under medicaid, and constitutes an inappropriate use of a services fund. In effect this recommendation may siphon off dollars from already over-taxed service delivery components and thus cripple the program. While the recommendation is left as a state option, it might also lead to regulatory problems of comparable magnitude to those encountered in nursing homes. [See the reports of the New York State Moreland Act Commission on Nursing Home and Residential Facilities: "Reimbursement of Nursing Home Property Costs: Pruning the Money Tree; Regulating Nursing Home Care: "The Paper Tiger"; New York State Moreland Act Commission, January 1976. Morris B. Abram, Chairman, Jonathan Weiner, Staff Director.] Mr. Abram states in the preface to these reports,

> When government funds flow in ever increasing sums, there is no assurance of anything except there will be a sufficiency of outstretched hands to receive the money. That the hands perform depends on government regulators.

Such use of medicaid funds, especially if through fiscal intermediaries could produce at best more bureaucracy, and at worst more fraud. Rather than see the purpose of medicaid compromised by such a recommendation, we would prefer to see this handled either by some form of increase in an income maintenance program or specific measures such as property tax relief—both of which address the issue more directly and equitably.

The provision that Medicare and Medicaid home health agencies and nursing home be required to utilize "cost-related" purchase has not proven to be an effective means of cost control.[12] In a situation where the government reimburses the states, who in turn contract with defined organizations or "providers" who in turn may subcontract with physicians, nurses, meal services, suppliers, etc., the line of audit control is so tenuous as to be impossible to enforce. To make fine distinction between transaction of this variety would require investigatory efforts. It may well be that under these circumstances the term cost-related has no substantative economic meaning in terms of controlling medicaid nursing home costs.

The advisability of including the chore services under medicare can be seriously questioned. The medicare program is primarily an insur-

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[11] Note experimental programs under 92–608, section 222 and as referred to below.

[12] Cost-related reimbursement (not purchase) as the term is presently used and enforced will go into effect under medicaid on July 1, 1976. However, divided opinions on what the term actually means, had lead to the contention on the one hand that states may place a limit on medicaid reimbursement and on the other hand that cost-related really means cost plus some amount in excess of cost.

ance program for the elderly which covers acute illness—hospitalization and physician care. It may be difficult to change the administrative and regulatory limitations of this primarily medical program when nonmedical services are included. Chore services are currently handled as part of title XX. Perhaps, some form of coordination of title XX and XVIII benefits would be possible under a new program designed especially for the elderly who are eligible under medicare.

Other recommendations under #6 which warrant further study include analysis of the impact of broadening provider eligibility status under medicare provision of home health care. What effect would inclusion of nurses, home health aides, etc. as registered providers have on all malpractice liability claims? Who would be legally responsible, if not a physician? How would this new provider arrangement affect underwriting of risks and cost of care?

The recommendation concerning Department of Professional Standards Review Organization (PSROs) for long-term care is already contained as part of legislative mandate under the PSRO Act. Currently this mandate is being contested by provider organizations and HEW has not yet developed definite regulations in this area, although there is a PSRO manual which could be used for long-term care review.

We do not question comprehensive home health care as outlined in the recommendations in a legislatively compatible national health insurance program. However, some of the specific proposals for national health insurance have goals which may be incompatible with those benefits directed almost exclusively toward the acute medical needs or catastrophic illnesses of the general population. Under such systems of national health insurance it may be more appropriate to consider a separate comprehensive long term care program which would include home health care, social and supportive community care through CHMC's and other facilities, day care centers, foster homes, congregate care facilities, as well as skilled and intermediate nursing facilities.

We wish also to clarify a possible misunderstanding which may result from the reading of the reports version of the recommendation under No. 6 to increase 100 visit home health limit of both Part A and Part B. The present medicare regulations under part B reads as follows: "Home health visits may be utilized only after Part A visits are exhausted." [13] This in effect does away with the non-hospitalization requirement and therefore does not allow home health care unless there has been prior hospitalization. This regulation clearly reflects an "institutional bias." We would recommend that post-hospitalization be removed from part A through legislation or at the minimum require the regulation under part B be changed to comply with the intent of the law.

Recommendation No. 8: "Amendment of Title XX of the Social Security Act to provide further financial incentives to maximize the prevention in reduction of inappropriate institutional care as much as possible in making home and community services available."

Of additional benefit to the elderly under this program would be a change in the title XX provisions to specifically define the elderly as

[13] Medicare Regulations, 20 CFR Part 405.

a group eligible for services under title XX. To date only Pennsylvania has chosen to separate services directed at senior citizens from services directed at the adult population as a whole. Without such a definition in title XX, it becomes difficult to account for amount of funds or the quantity and variety of services which are directed at senior citizens under any of the program objectives.

Recommendation No. 9: A series of demonstrations and pilot programs to determine the effectiveness of various home health and supportive services

We believe that demonstration projects such as outlined in the recommendations are appropriate means to determine the effect of particular home health benefits and services on defined populations, when such information is lacking. However, the report is somewhat inconsistent with its earlier mention of such demonstrations programs as proposed by HEW as superfluous or "delaying tactics" (SRC p. 24). If indeed there was sufficient data demonstrating the cost effectiveness and care advantages of home health additional demonstration programs would not be required. Apparently the subcommittee sees a need for several of them, including one calling for older persons to make "periodic visits to other elderly persons who are chronically ill and alone which already has been proven effective—" the so-called "friendly visitor programs" now eligible for support under the Administration on Aging. In this context we do not understand the statement made on p. 24 of the report, "that the time for relying on new experiments had ended and the time for meaningful legislative reform to make home health care reality is now."

Recommendation No. 13: Calls for a realistic open minded attitude by HEW toward home health legislation

There should be specific follow-up on the mandates of Congress in the home health area which have not yet been implemented.

We like our colleagues would urge the implementation of the White House Conference recommendations. One problem in calling on initiative by HEW in this report is that as an agency of the Administration, DHEW is in no position to require benefits or regulate more effectively where not under legislative mandate. For example, HEW can and should be more active in the area of enforcement of existing laws and regulations which govern the individual care of older Americans. To cite one example, HEW has never adequately enforced discharge planning requirements under medicaid and other Federal programs.[14] Consequently, while we theoretically have a mechanism which could back where deinstitutionalized persons are located and what care they receive, in fact such plans have not been adequately evaluated either with respect to their appropriateness to the patients need or adequacy of followthrough. The subcommittee should consider specific suggestions or oversight activities that would enable Congress and the Administration to work together to see that the elderly receive better home health care.

Recommendation No. 14: Establishing and expansion of outpatient clinics specializing in geriatrics

We support some of the recommendations contained under this rubric. We believe, however, that any construction of additional facil-

[14] GAO study of Discharge Planning Requirements. In process.

ities to serve the elderly should take into account the availability of existing clinics and ambulatory care services in the community generally and the priority needs for construction of new facilities of whatever type for long term care. This could be accomplished through Public Law 93-647, the National Health and Planning Act.

It may be that for a particular locale, region, or state, additional skilled nursing or intermediate beds are needed more than a separate ambulatory clinic for senior citizens. For example a recent Pennsylvania study projects a need for 35,000 new nursing home beds in the state by 1980, with capital expenditures to update present facilities to Life Safety Code requirement and to construct new facilities estimated at $1 billion.

In any event both the requirement of rational regional planning and the necessity for controlling construction in renovation costs should be considered before embarking on any building program of this magnitude.

An essential aspect of developing responsive outpatient care for older persons, is in the area of training of medical and social service personnel. The need for personnel specially trained and equipped to deal with geriatric problems in hospitals, outpatient clinics, community mental health centers, day care facilities, and nursing homes may exceed that of the need for new facilities. The subcommittee should not orient its recommendations to "edifices" so much as it does to personal care per se.

A case might be made that a more appropriate locus for such services is in the area of congregate housing. To date "housing" for the elderly with services has been a little utilized or understood alternative to inappropriate institutionalization. This is the case in part because of the tendency to dichotomize sharply between institutionalization and its alternatives. This leads to the view that either one is placed in a nursing home or one must receive services in their private place of residence. Actually there is a potential for the use of many facilities in the community as congregate care facilities under an appropriate system of regulation. This approach is not without danger as witnesses the difficulties that states have had in bringing up to standard boarding homes for the elderly.

A recent information bulletin released in January of 1976 in the House Mortgage Credit Department of HUD entitled "Section 202, Loans for Housing for The Elderly and Handicapped", yielded the following information: Applications were received from over 1,500 projects under HUD Section 202, with request for financing of over 230,000 units for the elderly and handicapped. Under the present system of allocation only about 12,610 units will be funded. The "Ad Hoc Coalition for Elderly Housing" has been told by HUD officials that although there are approximately 800 well qualified, experienced, sponsors applying for 202 money, only about 60 to 100 of those sponsors will receive funds. This significant unmet need calls for a swift and flexible response. The Subcommittee should investigate this area further in coordination with the Subcommittee on Housing and Consumer Interests for the purposes of drafting policy and legislative recommendations. This is a clear case where there must be eventual coordination not only within HEW, but between HEW and HUD.

The amendment to reimburse deductible and co-insurance fees to hospitals providing in-patient services for patients referred by non-profit comprehensive out-patient centers may not accomplish what was intended. The recommendation may lead to successful working arrangements between non-profit comprehensive out-patient centers and hospitals, but it will result in inappropriate over-utilization of high cost hospital beds. The recommendation in effect structures extra cost into the program. It is unclear how such a reimbursement provision would make the length of in-patients stay more appropriate to his needs. Placement in residential and community care settings with adequate physician or nursing care may in some instances be a better alternative.

The subcommittee appropriately recognizes the excellence of the Minneapolis Age and Opportunity Center—MAO. However, to call for the appropriation of a half million dollars specifically directed at this institution when there are many other programs with organizational structures, systems, financial arrangements and evaluation methodologies which might be equally shared with the field is inappropriate. The subcommittee has collected information from over 20 such organizations including many which have equal reputations in their area. Among them are On-Lok Senior Health Services in Chinatown, San Francisco, Calif.; Philadelphia Geriatrics Center, Philadelphia, Pa.; Levendale Day Care Program, Baltimore, Md.; Project Independence, Scoggin, Franklin, and Oxford Counties, Maine; Triage, Connecticut Department on Aging; and St. Camillus Care Center, Syracuse, N.Y. Federal support of collation and dissemination of information which would promote multipurpose of care organizations of this type may be a necessary prelude to full implementation of community long-term care centers as recommended in No. 1. However, we believe both the amount funding available for this purpose and the specific targeting to a center which is sometimes regarded as the unique reflection of one individual's successful efforts to meet the health care exigencies in her community, is unwise. These or similar dollars, if they are made available, should be distributed on a competitive basis, or by other criteria which qualifies such organizations for wider application.

The recommendation which calls for medicaid to reimburse the cost of transportation for disabled and for those over 60 to and from outpatient clinics should be clarified as some transportation costs are already covered by medicaid. As the subcommittee recommends additional free standing clinics under medicaid additional transportation services should be covered.

It is our sincere hope that the recommendations contained in the subcommittee report and its supplementary views will initiate urgently needed reforms in all levels of health care for the elderly, whose health is one of America's great resources.

H. John Heinz III.
William S. Cohen.
William F. Walsh.
Charles E. Grassley.
John Paul Hammerschmidt.
Gilbert Gude.

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